CDI study guide on payment and regulatory updates
FEATURES

7  Concurrent coding
Much like concurrent CDI reviews, the concurrent coding process necessitates that the coding professional follow the chart throughout the patient’s whole admission and code it at intervals.

12 CMS-HCC version 23 released
Like all reporting structures, CMS updates its HCC list each year. The newest version contains some notable additions that CDI professionals should be aware of.

17 Mortality reviews and publicly reported quality scores
When a patient comes into the hospital and, despite the medical staff’s best efforts, dies, the documentation in the record should accurately reflect how truly sick the patient was.

25 Submit questions to Coding Clinic
When a frustrating coding program arises and there’s no clear answer, CentraCare Health—St. Cloud Hospital takes their questions straight to Coding Clinic.

DEPARTMENTS

3  Associate Director’s Note
Melissa Varnavas explains why CDI professionals need to stay abreast of the changing healthcare environment.

5  Note from the ACDIS Advisory Board
Sam Antonios discusses how CDI can stay relevant has healthcare changes around them by staying attune to their customer’s needs.

10  Ask ACDIS
Candace Blankenship unpacks SOI/ROM scores in the APR-DRG system.

20  From the Forum
Allen Frady discusses the process for choosing a principal diagnosis.

28 Coding Clinic for CDI
Sharme Brodie explains the contents of the third quarter Coding Clinic release for CDI professionals.

31  Physician Advisor’s Corner
Trey La Charité shares several ways in which the EHR impacts physician documentation and CDI’s work.

34  Meet-a-Member
Dianne Rodrigue is a senior manager at Baker Newman Noyes, a public accounting firm in New England, based in Portland, Maine, with a healthcare advisory and consulting division. She is also a member of the Maine chapter of ACDIS.

OPINIONS & INSIGHTS

15  New global malnutrition definition
Richard Pinson and Cynthia Tang unpack the nuances of the new malnutrition definition and its implications for CDI.

22  Sepsis equals a dysregulated host response to infection
Cesar M. Limjoco explains the various sepsis criteria and how they affect CDI’s work.

CONTINUING EDUCATION CREDITS

BONUS: Obtain one (1) CEU for reading this Journal
ACDIS members are entitled to one continuing education credit for reading the CDI Journal and taking the 20-question quiz. Visit the November/December Journal page on the ACDIS website to take the quiz.
Panta rhei: All things change

by Melissa Varnavas

It’s that time of the year again: time to pull down the tome that is the inpatient prospective payment system (IPPS) final rule and mine its pages for changes relevant to daily CDI reviews. While intimidating at more than 600 pages, the IPPS rule can be broken into digestible bits, including changes to the ICD-10-CM/PCS code set and shifts in CC/MCC designations. It also frequently includes a number of healthcare payment initiatives that seek to implement reimbursement reforms put in place by government regulations such as the Affordable Care Act.

This year, the final rule brought an overhaul of the Electronic Health Record Incentive Programs, renaming them Promoting Interoperability Programs (PIP). It also ushered in significant reductions to reporting requirements for quality initiatives, updates to payment rates, and the aforementioned CC/MCC changes, which, according to Allen Frady, RN, BSN, CCDS, CCS, CRC, CDI education specialist for ACDIS and HCPro based in Middleton, Massachusetts, include:

1. Acute respiratory distress syndrome is now an MCC
2. Sepsis following an obstetrics procedure can be coded and is an MCC
3. Sepsis following a procedure (initial encounter as a secondary diagnosis) now provides a CC
4. Congenital Zika virus is an MCC
5. Appendicitis has new codes for patients with peritonitis who may or may not have a rupture and may or may not have an abscess
6. HIV disease is no longer an MCC; it was downgraded to a CC
7. Encephalopathy unspecified or other are no longer MCCs; they’ve been downgraded to CCs
8. Cholangitis is no longer guaranteed a CC
9. New codes were added for insertion of pacemakers
10. New codes were added for adult and child labor/sexual exploitation and are designated as CCs

While CMS continues to move away from fee-for-service reimbursement, the agency also aims to reduce administrative burdens on providers—cutting the proverbial red tape, it says. In that vein, CMS
removed a number of quality reporting and pay-for-performance program measures in this year’s IPPS final rule, including 18 previously adopted measures that have been topped out, have not resulted in better patient outcomes, or have associated costs that outweigh the benefit of their continued use in the program, according to the agency. For example, the “safe surgery checklist use” measure was removed because it did not result in better outcomes. Similarly, the “stroke education” measure was removed because the costs outweigh the benefits of its continued use, CMS said in its release.

CMS is also de-duplicating 21 measures, meaning that while the measure may fall off the list in one program, it may remain on the list in one of the other three (the Hospital Inpatient Quality Reporting Program, the Hospital Value-Based Purchasing Program, the Hospital Readmissions Reduction Program, or the Hospital-Acquired Condition [HAC] Reduction Program) to simplify and streamline measures across programs, Revenue Cycle Advisor reported. For example, the catheter-associated urinary tract infection and the central line–associated bloodstream infection outcome measures were removed from all programs besides the HAC Reduction Program. And six healthcare-associated infection patient safety measures that are being de-duplicated will be removed for calendar year 2020, one year later than originally proposed in April.

The IPPS also removes the requirement that a written inpatient admission order be present in the medical record as a specific condition of Medicare Part A payment—as a means to reduce the number of denied claims for clerical errors, according to CMS.

One of the key provisions of PIP includes finalizing a new performance-based scoring methodology consisting of a smaller set of objectives, according to Revenue Cycle Advisor. This, CMS says, will provide a more flexible, less burdensome structure, allowing eligible hospitals to refocus on patients.

Another large change included in this year’s IPPS final rule is a requirement for hospitals to establish and make public a list of standard charges, and to update this information annually (or more often, as appropriate) in order to encourage price transparency by improving public accessibility of charge information.

The release of the IPPS final rule is an opportunity for CDI professionals to step back from their everyday practices and take a broader look at the healthcare industry, to ask questions about the effect of regulatory changes on physician and facility reimbursement, and thereby on patient care.

CDI professionals need to not only identify how these changes affect what type of documentation details are needed in the record, but to understand why these changes matter. Such understanding goes a long way toward a sense of professional accomplishment, but it also allows professionals to effectively communicate the inherent value of CDI work to any vested party (read: naysayer physicians or difficult administrators) who may question not only the program’s purpose, but its underlying value and return on investment.

Panta rhei. All things change, as Heraclitus said.

It’s not just the IPPS rule that brings changes with it, either. In this edition of the CDI Journal, we look at advancements in concurrent coding within CDI efforts, changes to the Hierarchical Condition Categories that CDI professionals should be aware of, and the most recent guidance from AHA Coding Clinic, along with a case study regarding how CentraCare Health composes its questions to the Coding Clinic editorial board.

There’s also new recommendations from the international medical community on malnutrition definitions called “Global Leadership Initiative on Malnutrition,” or GLIM; suggestions on how to handle sepsis cases; new efforts within mortality reviews; and information regarding how principal and secondary diagnosis capture affects severity of illness and risk of mortality in the APR-DRG risk management system.

Change happens. Luckily, the CDI profession is particularly adept at managing it.

If you have a story to share regarding your own change management processes, please let us know. We’d love to share it with the ACDIS community. 🌟
Stay relevant in changing healthcare landscape

By Sam Antonios, MD, MMM, FACP, SFHM, CPE, CCDS

Consider the story of a patient—say, a pneumonia patient—whose treatment cost a lot of money. The hospital’s reimbursement for that care, however, was less than the cost of providing it.

Now say someone looked at that case and how complex it was, and then saw that the reimbursement only paid for half the cost of caring for that patient. That’s how clinical documentation improvement (CDI) was born.

To put it simply, CDI was formed because there were data errors that led to financial cost. However, continuing with the same focus and method—reviewing records for accurate reimbursement—is myopic.

Healthcare is changing around us, and CDI has to change and adapt with it in order to stay relevant.

It’s helpful to think of CDI as a business. When you do, think about what your business is and who your customers are. Remember the video rental chain Blockbuster? They thought they were in the business of renting and selling DVDs and forgot they were actually an entertainment business. As a result, they became irrelevant and failed when Netflix came around.

In contrast, think of a company like Amazon that started out selling books, but diversified its offerings to vastly increase its value to customers—because like Netflix, and unlike Blockbuster, Amazon understood the business it was in.

When we perceive CDI as a business with a customer base, the industry will remain viable for the next stage in healthcare’s evolution.

Remember that while you may report things like CC/MCC capture rates to the chief financial
officer, that person doesn’t actually care about the CCs and MCCs themselves; he or she cares about the accuracy of the data.

The business administrators care about improving data and reducing errors, which ultimately results in a healthier organization. While these discrepancies focused on the financial health of the organization 15 years ago, we’re seeing the same thing with quality now.

The good news is that CDI can adapt to that change and remain relevant. CDI is in the business of data integrity, and that’s a far-reaching occupation.

For instance, say there’s a report showing a terrible compliance rate with a particular quality measure, but it turns out the physicians were just adding the required information to the wrong box in the EHR. CDI professionals, for whom data integrity is the watchword, are in line to help educate providers on these types of issues.

“You have to have a broad, comprehensive, and open-minded view of CDI’s role to succeed in this environment. If you remain in the business of CC/MCC capture, you’re going to send up like Blockbuster.”

Sam Antonios, MD, MMM, FACP, SFHM, CPE, CCDS

information to the wrong box in the EHR. CDI professionals, for whom data integrity is the watchword, are in line to help educate providers on these types of issues.

You have to have a broad, comprehensive, and open-minded view of CDI’s role to succeed in this environment. If you remain in the business of CC/MCC capture, you’re going to end up like Blockbuster.

Additionally, diversifying and adapting will help combat one of the biggest threats I see for CDI today: outsourcing. Unfortunately, coders have been relegated to the background to code records, meaning they’ve created a perfect job to be outsourced. Such a risk still exists for CDI.

While this change likely wouldn’t happen overnight, it is a distinct possibility if we continue doing the same thing we’ve done forever. I don’t mean to sound pessimistic about the situation; I’m simply looking at the history of other professions. So many jobs that haven’t diversified have gone away.

So, what can you do to prevent a slide into irrelevancy? The answer is relatively simple: Make yourself invaluable to your organization. As a data integrity specialist, you are well-situated to help with a number of emerging problems for your organization.

My recommendation for every CDI professional is to find a situation that your organization is struggling with, any type of work that no one else is interested in, and take on that project. That’s how you can prove value. Volunteering for a job that is difficult or no one else is doing is called leadership.

Let’s go back to the example of the data entry error causing an issue with quality reporting. Working with the information technology staff to develop, implement, or educate on the use of a particular part of the EHR isn’t traditionally included in CDI work. But, that work helps ensure that the organization’s data is accurate, and that is in CDI’s wheelhouse.

Plus, it puts another skill in the CDI tool belt and helps prove the continued value of the CDI staff in ways that can’t easily be outsourced or automated.

So, as healthcare changes, remember to think about your business. Focus on the organization’s needs and CDI will go the way of Amazon.

Editor’s note: Antonios is the chief medical officer Via Christi Hospitals, in Wichita, Kansas, and a member of the ACDIS Advisory Board serving through April 2019. The opinions expressed do not represent a consensus agreement of ACDIS or its Advisory Board. Contact Antonios at samantonios@outlook.com.
Much like concurrent CDI reviews, the concurrent coding process necessitates that the coding professional follow the chart throughout the patient’s admission and code it at intervals. The hope is that this process limits the number of clarifications needed after discharge, allowing the organization to send the final bill sooner rather than later. According to a recent ACDIS survey, 47.51% of the 603 respondents currently have a concurrent coding program.

The mechanics of the concurrent coding process can cause headaches for both CDI and coding professionals alike. Plus, one could argue that CDI’s presence itself limits the number of necessary post-discharge clarifications without the process of concurrent coding.

So, why should CDI programs get involved with this process?

**Accurate real-time reporting**

Since coded data is used for so many things now, the accuracy of that data has never been more important. The practice of concurrent coding ensures the data is accurate, in real time, with the patient’s stay.

Plus, as the chart is coded concurrently, the CDI specialists are able to immediately see where coding difficulties may arise, says Diana Ortiz, JD, RN, CCDS, CDI product owner at 3M Health Information Systems in Murray, Utah.

“I don’t want to say things were more accurate [with a concurrent coding process in place], but things were accurate quicker,” Ortiz says of implementing a concurrent coding program at her previous facility. “It also helps with the back-end reconciliation process.”

And knowing how the chart will code out concurrently doesn’t only help CDI, Ortiz adds. According to the ACDIS survey, 53.05% of respondents say that the goal of their concurrent coding program is to improve coding of potential quality indicators during the patient’s stay.

“A lot of the time, the quality team is looking at the [more] basic coding that CDI specialists are [traditionally] doing concurrently. Because coders are more in tune with coding guidelines than CDI specialists, there may be differences in final coding versus working codes,” she says. “Following those quality measures more concurrently from a better [clinical and coding] truth perspective is a good thing.”
In fact, the accuracy of quality measures may be the exact thing a new concurrent program focuses on. That’s the case for CentraState Medical Center in Freehold, New Jersey, which only performs concurrent coding on charts suspected to include a hospital-acquired condition (HAC) or a Patient Safety Indicator (PSI), says Christine Butka, RN, MSN, CCDS, CDI manager at CentraState.

In such situations, CDI staff refer the case to Butka for review. If she comes to the same conclusion as the original reviewer, she turns it over to the coding manager, who assigns the chart to a coding professional to perform concurrent coding.

“CDI doesn’t always know the specificities of a procedure, so the coders help us understand the real codes that are going to appear on the chart and if they trigger a quality measure,” she says.

If the coding team agrees that the situation could trigger a PSI or HAC, Butka and her team have an opportunity to re-review the chart to ensure any conditions that might “exclude” the case from PSI or HAC measures get documented accurately before the chart is final coded and the bill is dropped.

Even if the case does ultimately fall into a HAC or PSI, she says the process still saves the CDI staff time in the long run and allows the chart to be billed in a timelier manner.

“It helps us get the patients out of the PSI or HAC, if we can, during the stay or it helps us understand if we’ve triggered it so we don’t have to do that work of figuring it out on the back end,” says Butka.

The process also makes things a bit easier on the physicians. Since the clarifications all happen concurrently, it eliminates the strain of post-discharge queries once physicians have moved on to other cases and concerns.

“If you try to get the quality piece figured out after the fact, the doctor probably doesn’t want to hear it since the patient was discharged the month before,” she says.

Better communication between CDI and coding

CDI professionals have always served as a bridge between the clinical and coding worlds, but concurrent coding can broaden and diversify that avenue of communication.

“The collaboration between coding and CDI is a huge benefit,” says Ortiz. “Both teams should come together and try to figure things out quicker.”

Since the coding professional and the CDI specialist are both concurrently in the record, there are more opportunities to communicate about the case and share coding and clinical concepts as their expertise allows, Ortiz says.

“Ideally, responsibility for the code set should be with the coding team,” she says. “It really makes sense for CDI to own all the queries, all the clinical side of things, and the physician education piece.”

The division of labor plays to each group’s strengths rather than asking everyone to be an expert in everything.

“We really wanted to lean on the expertise of the coders to help us,” says Butka. Even when CDI professionals come from an HIM/coding background, their skill set will shift since their CDI role doesn’t have them coding charts daily.

Having a coding professional in the record with the CDI professional will illuminate any misunderstandings and ensure that the documentation is sufficient for both painting the clinical picture and translating it into codes.

Advice for concurrent coding implementation

Of course, the relationship between CDI and coding isn’t necessarily smooth sailing. In fact, according to 41.78% of the survey respondents, the main barrier to implementing a concurrent coding program is a lack of CDI/coding collaboration. To eliminate that barrier, Ortiz suggests administrators provide clear goals to focus concurrent efforts.

Those starting a concurrent coding program should “figure out exactly what they want to achieve for their organization,” she says. “There’s lots of benefits, but what’s the benefit for you?”
Without a clear focus, it will be difficult to get people on board with the project and keep the ball rolling as time goes on. Once you’ve set your goals, it’s time to plan the implementation process, Butka adds.

“I think you have to get the process down from a CDI and from a coding perspective. You can’t just say, ‘Hey, code this chart and walk away,’” she says. “You have to figure out the step-by-step process.”

Though that process will ultimately make the project go smoother, implementation will probably have some hiccups. “I won’t say it didn’t come without pain, but we really had to start by looking at the process,” Ortiz says.

For Ortiz and her team at the time, they started with some “super users” from both the CDI and coding teams—people who knew the technology and workflow inside and out and were comfortable with learning new processes in the system.

“Best practice should include documentation of the final process so it remains adaptable and can be scaled,” she says.

Once the process is documented, the workflow can be tweaked along the way. According to Ortiz, determining the best rollout method for an organization is critical to avoid negative impact to the discharged-not-final-billed list (DNFB).

If the goal of an organization is to decrease the DNFB, implementing concurrent coding across all service lines or all payers can introduce an element of risk—if the new process fails, there’s a danger of administrators eliminating the experiment. Rolling out by service line, payer, or facility allows the CDI staff to identify obstacles, adjust, and make changes ahead of the next phase of implementation.

“While there is an opportunity to implement organizationwide, all at once, an organization has to decide whether they are willing to take that risk,” says Ortiz.

Since Butka’s facility uses a hybrid medical record, their approach was a bit different. They started with education—namely, where to find documents in the medical record when they haven’t been scanned into the EHR yet.

“We had to have the coders come up on the floor with us and see the whole process,” says Butka. “They’re used to having everything scanned in the EHR, so they had to be trained in knowing where everything would be in the chart to concurrently code it.”

While the CDI specialists were used to being on the floor and finding things in the chart, the coding team wasn’t, Butka says. Then, CDI had to help the coding team understand the process and purpose of the project, she says.

“One of the difficulties was having the coders understand that they have to code everything in the chart during this process,” says Butka. “It’s hard for them to code something that’s incomplete. What if this code I’m putting in is ruled out five days from now?”

This educational process can be summed up as “change management,” says Ortiz—meaning the process by which people are prepared for upcoming changes.

“There’s a human component to it, and you have to have buy-in from people,” Ortiz adds. “At least philosophically, you can’t spend enough time on the change management.”

One way to prepare the coding and CDI teams for the change, according to Butka, is to do some practice runs before the program goes live.

“I’d recommend having the coders practice concurrent coding before they’re actually doing it so they’re used to the process and where everything is in the chart,” she says. That way, you’re not asking coding professionals to do something out of the blue with no process instruction or guidelines.

Once you’ve done your homework, set goals for the program, and developed a process for the project, the concurrent program can go live. However, that doesn’t mean it’ll stay the same for the rest of time, Ortiz says. You have to do what works best for your CDI and coding staff, as well as what’s best for the organization, she says.

“Just because you set out on a path doesn’t mean it won’t change and evolve. You have to stay open,” she says. “It’s really just the beginning of further expanding collaboration to improve clinical documentation.”
Unpacking SOI/ROM scores in the APR-DRG system

Q: What is the difference between the severity of illness (SOI)/risk of mortality (ROM) in the APR-DRG arena? For example, DRG 280 with APR 190, 4/4, and the individual code SOI/ROM.

Let’s say you have a patient with a ST-elevation myocardial infarction (STEMI), acute respiratory failure on mechanical ventilation, diabetes mellitus (DM) with hyperosmolar hyperglycemic state, shock, etc. and the DRG is DRG 280 (MI) with 4/4 for SOI/ROM. The patient is unresponsive and was comatose with a Glasgow Coma Scale score of 3 at the transferring facility. Your facility receives the patient to do a heart catheterization for the STEMI. You are already at a 4/4, but you wonder if the patient has Type 1 DM with ketoacidosis without coma instead of Type 1 DM with ketoacidosis with coma. The individual SOI/ROM for Type 1 DM with ketoacidosis without coma is 3/3, but since these values are not underlined, the encoder’s logic indicates that this diagnosis has no impact on the total SOI/ROM score when the principal diagnosis is STEMI. In this scenario, the total SOI/ROM score is 4/4 as you noted in your question.

A: In the APR-DRG system, not every secondary diagnosis will have an effect on the final SOI/ROM score. The difference is the coma. Let me show you:

Here is your first scenario of a patient with the principal (P) diagnosis of STEMI and the secondary diagnoses of acute respiratory failure, shock, and Type 1 DM with ketoacidosis without coma:

<table>
<thead>
<tr>
<th>SOI</th>
<th>ROM</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>4</td>
<td>Acute Respiratory Failure</td>
</tr>
<tr>
<td>4</td>
<td>3</td>
<td>Type 1 DM with ketoacidosis w/o coma</td>
</tr>
</tbody>
</table>

Secondary diagnoses that have an impact are identified with an underline above. In the scenario described, only acute respiratory failure and shock affect the final SOI/ROM score when the principal diagnosis is STEMI. The Type 1 DM with ketoacidosis without coma has an SOI/ROM value of 3/3, but since these values are not underlined, the encoder’s logic indicates that this diagnosis has no impact on the total SOI/ROM score when the principal diagnosis is STEMI. In this scenario, the total SOI/ROM score is 4/4 as you noted in your question. This 4/4 score is the sum total of the principal diagnosis of STEMI with the secondary diagnoses of acute respiratory failure and shock.

In your second scenario, the patient is admitted with the principal diagnosis of STEMI and the secondary diagnosis of acute respiratory failure, shock, and Type 1 DM with ketoacidosis with coma:

<table>
<thead>
<tr>
<th>SOI</th>
<th>ROM</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>3</td>
<td>DM1 w/ketoacidosis and coma</td>
</tr>
<tr>
<td>4</td>
<td>4</td>
<td>Shock</td>
</tr>
</tbody>
</table>

Now all of the diagnoses have an effect on either SOI or ROM on the final score for the principal diagnosis of STEMI. The secondary diagnosis of shock has been demoted to only effecting the ROM score, but the Type 1 DM with ketoacidosis and coma has been promoted in both value and effect. Type 1 DM with ketoacidosis and coma has moved from an SOI of 3 to an SOI of 4. Now its SOI score is underlined, which indicates that it will affect the final SOI/ROM score for STEMI. You still get a final SOI/ROM of 4/4, but you got there along a different path.

Let’s look at one more scenario. Say the patient is admitted with the
principal diagnosis of STEMI and the secondary diagnoses of acute respiratory failure, shock, and unspecified coma:

<table>
<thead>
<tr>
<th>SOI</th>
<th>ROM</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>4</td>
<td>Acute Respiratory Failure</td>
</tr>
<tr>
<td>4</td>
<td>4</td>
<td>Coma, unspecified</td>
</tr>
<tr>
<td>4</td>
<td>4</td>
<td>Shock</td>
</tr>
</tbody>
</table>

The secondary diagnosis of coma pushes the secondary diagnosis of shock out of the way. Shock now has no effect on the final SOI/ROM score for STEMI.

You still get a final SOI/ROM of 4/4, but you took a different path. I think when you compare these three scenarios, it’s clear that the addition of coma, whether with Type 1 DM or by itself, is the force that moves the SOI/ROM value and effect for the secondary diagnosis.

Keep in mind when using the APR-DRG coding system that there are variables within the logic that will change the SOI/ROM score and impact value of the secondary diagnosis. Some of these are:

- **SOI/ROM scores can vary depending on the patient’s age:** Many secondary diagnoses coded for a 40-year-old male patient will have lower SOI/ROM scores than the same secondary diagnoses for a 70-year-old male patient. SOI/ROM scores for secondary diagnoses in pediatric patients are different from those of young adults; they’re similar to SOI/ROM values for elderly patients.

- **The relationship between the secondary diagnosis and the principal diagnosis:** When the principal diagnosis is sepsis, the secondary diagnosis of dehydration has an SOI/ROM of 2/2. When the principal diagnosis is heart failure, dehydration has a value of 2/3.

- **The relationship between two secondary diagnoses can be synergistic:** When the principal diagnosis is sepsis, acute kidney injury (AKI) has an SOI/ROM value of 3/3. But when you add in the secondary diagnosis of dehydration to the coding profile, AKI changes to 3/3.

- **Some Z codes and procedure codes can alter the SOI/ROM score for the principal diagnosis:** Z95811, presence of heart assist device, has an SOI/ROM value of 3/2 as a secondary diagnosis.

As to your second question about whether you would query for coma, CDI’s goal is to obtain the most accurate description of the patient in the health record. This description is used by various entities to determine reimbursement, quality ratings, and risk adjustment. Let’s look at these scenarios again.

The first patient presents with a new STEMI, acute respiratory failure, shock, and Type 1 DM with ketoacidosis without coma. From a CDI perspective, this patient is good at an SOI/ROM of 4/4. From a clinical standpoint, this patient looks like an ICU nurse would expect. The patient just experienced an acute event (STEMI), and the nurse would expect that the respiratory failure, the shock, and the ketoacidosis would be temporary.

The second patient presents with a new STEMI, acute respiratory failure, and Type 1 DM with ketoacidosis with coma. Again, from a CDI perspective, this patient is good at 4/4. But from a clinical standpoint, this patient is more complicated than the first, and the ICU nurse is probably more concerned about the patient’s chance of full recovery.

The third patient presents with a new STEMI, acute respiratory failure, and coma. CDI once again says this patient is good to go at 4/4. However, the ICU nurse who is taking care of this patient is likely very worried. The coma is probably indicative of an anoxic brain injury, and the ICU nurse will know that the patient’s chance of full recovery is very poor.

So, would I query for coma in a patient with a new STEMI? Yes. The reason is that the coma further describes the high risk of mortality and morbidity in this patient and will affect my risk adjustment scores for quality and mortality outcomes.

**Editor’s note:** Candace Blankenship, RN, BSN, CCDS, a CDI specialist at Johns Hopkins Health System in Baltimore, answered this question. She is a member of the Maryland ACDIS chapter and of the ACDIS Regulatory Committee, and a contributor for the book *Pediatric CDI: Building Blocks for Success*. Contact her at cblanke4@jhu.edu.
Beyond outpatient: CMS-HCC version 23 released

Like all reporting structures, CMS updates its Hierarchical Condition Category (HCC) list each year. Recently, version 23 was released, and it contains some notable additions that CDI professionals—whether inpatient or outpatient—should be aware of.

The HCC model is a risk-adjustment methodology used for Medicare Advantage, population benchmarking for Accountable Care Organizations, and quality programs. In some cases, conditions that qualify for an HCC also count as CCs/MCCs in the MS-DRG system.

With version 23, CMS added several categories in the mental health area and one to the chronic kidney disease (CKD) grouping. While mental health may not be a common review focus for CDI professionals, capturing those conditions is paramount for accurate reporting and reimbursement. (See p. X for a list of the additions.)

“If you don’t know the level of specificity for code assignment, then you could be affected financially and/or with meeting quality measures.”
Tammy Combs, RN, MSN, CCS, CCDS, CDIP

“...financially and/or with meeting quality measures,” says Tammy Combs, RN, MSN, CCS, CCDS, CDIP, director of HIM practice excellence and CDI/nurse planner for AHIMA. Denials management may also be affected, she says. “Anytime you have codes assigned, they need to be supported by the documentation.”

Mental health and substance use additions

With an increased focus on population health, it’s not surprising to see mental health issues added, according to Sonia Trepina, MPA, director or ambulatory CDI services for Enjoin CDI in Collierville, TN.

“I was excited to see the additions under the mental health and substance abuse categories because we know that those conditions take time, resources, and money to...
care for. Population health is such an important development in our industry, and I think this recognizes that evolution,” she says. “Capturing these codes will give us the data we need to determine what industry improvements and changes are needed to care for patients with these conditions.”

The additions to the mental health category allow for great specificity when it comes to the type and nature of the mental health or substance use condition. Adding this specificity, Combs says, will help the healthcare industry better care for these patients since “we’ll have a better read on the actual numbers behind these conditions. Various research and treatments are being planned and evolved, all based on the documentation. That’s where my initial thought goes. It’s all about identifying those conditions.”

Of course, CDI professionals will likely need to provide education to the medical staff surrounding these changes.

“The language that the providers use isn’t necessarily the language that will trigger an HCC,” says Brett Senor, MD, CRC, CCDS, physician associate for Enjoin. “If you asked me whether ‘major depressive disorder’ was enough and I didn’t know better, I would think it was.”

Education has to begin with the CDI professionals themselves, though, says Gloryanne Bryant, RHIA, CDIP, CCS, CCDS, former national director of coding, quality, education, systems, and support for a national healthcare delivery system (now retired).

“This may be an area some of the CDI specialists haven’t been exposed to because it’s mental health, not physical health, so they may need to read up on those conditions,” she says. “Maybe reach out to someone in the mental health department, the ED physicians, and then the hospitalists. There are mental health workers who aren’t physicians, too. They would be another good group to talk with now.”

Once the CDI staff has done their research, they’ll be able to present a united front to the physicians and ensure they’re passing along accurate information. During reviews,

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**CMS-HCC VERSION 23 ADDITIONS**

Four new HCCs were added to CMS’ version 23 model, which brings the total number of HCCs up to 83. The changes are predominantly in the depression and substance use areas with the exception of CKD stage III.

Here’s an overview of what’s been added:

- **HCC 55:** Holds the same ethanol (ETOH) dependence and now also includes a variety of accidental or undetermined poisoning conditions.

- **HCC 56:** This new category now breaks out abuse, uncomplicated, and abuse, in remission for: opioid, sedatives, cocaine, other stimulants, hallucinogens, inhalants, and other psychoactive substances. It excludes ETOH. It is the lowest rung in the hierarchy (with HCC 57, schizophrénias, as the most severe rung).

- **HCC 58:** Now only includes psychotic disorders and psychosis.

- **HCC 59:** This new category includes mania, major depressive disorder, bipolar, poisoning due to self-harm, and other self-harm activity. In version 22, “other self-harm activity” was included in HCC 58 with a higher weight.

- **HCC 60:** This new category includes dissociative fugues, stupor, identity disorders, OCD, and narcissism. It is the lowest category in the hierarchy.

- **HCC 138:** This new category falls into the renal hierarchy and captures CKD stage III. It only includes ICD-10 code N18.3, and it is the lowest category in its hierarchy.

All the documents and spreadsheets related to CMS-HCC version 23 can be found on the CMS website.
Bryant suggests keeping an eye out for psych assessments and consults. “We may need to query for some of these mental health conditions now,” she says.

“This may be an area some of the CDI specialists haven’t been exposed to because it’s mental health not physical health, so they may need to read up on those conditions.”

Gloryanne Bryant, RHIA, CDIP, CCS, CCDS

In the short term, the new mental health categories will likely add some work for CDI professionals in regard to self-education, physician education, and review time.

However, in the long term, the new categories will give the industry more data surrounding mental health concerns and help shape better treatments and guidelines, says Senor—which speaks to the larger population health mission of CDI.

“By expanding the number of diagnoses, it really expands the awareness of psychiatric disorders,” he says.

**CKD stage III**

Though HCCs existed for the other stages of CKD in previous versions, version 23 was the first to add a category for CKD stage III. While this is a relatively small change in comparison to the multiple changes in the mental health category, it validates CDI specialists’ pursuit of CKD staging, Combs says.

“I think it’s something we’ve always been looking for, so it solidifies the need to look for that,” she says.

Before this addition, CKD stage III could be captured in the MS-DRG system, but it didn’t have a corresponding HCC. According to Senor, the addition allows for better reporting of a very common type of CKD.

“CKD stage III, in my experience, is the most common stage of CKD, but it wasn’t risk-adjusted before. You can also capture it even on the inpatient side with the interactions with the CKD too, which means it’s more than an outpatient issue,” like with hypertensive heart disease, he says.

The new CKD category could also make a big financial difference for hospitals, according to Trepina.

“CKD stage III, in my experience, is the most common stage of CKD, but it wasn’t risk-adjusted before. You can also capture it even on the inpatient side with the interactions with the CKD too, which means it’s more than an outpatient issue,” like with hypertensive heart disease, he says.

The new CKD category could also make a big financial difference for hospitals, according to Trepina.

“We see a lot of CKD stage III treated, and if you add that count up, you’re definitely looking at some dollar impact that’s been missing,” she says.

**Inpatient concerns**

While the most common location for capturing HCCs is in an outpatient setting (for example, at the patient’s primary care office) because of the often chronic nature of the conditions, they don’t have to be captured in that setting.

“You think HCCs and you think outpatient, but with CDI professionals, they need to be thinking of the continuum of care,” says Combs. “Instead of just focusing on what needs to be documented on the inpatient side, let’s look for high-quality documentation.”

Plus, there’s actually a fair bit of overlap between the conditions traditionally focused on by inpatient CDI professionals and those under the purview of outpatient CDI professionals, Senor says.

“I would probably encourage inpatient CDI specialists to be aware of where there is overlap between HCCs and CC/MCCs,” he says. “You don’t want query fatigue, so you need to know where the impact is.”

Before diving into HCC reviews, Trepina echoes Senor’s advice to find where you’ll have the most effect.

“Start with chart reviews,” she says. “From there, depending on the results, you can start with the physician education and some level of querying.”

Though HCCs may be outside your usual realm of review focus areas if you work on the inpatient side of things, Combs says to keep the focus on documentation quality at the forefront of your reviews.

Understanding the coding guidelines and updates to ensure documentation correctly translates to codes is helpful and sometimes necessary, but don’t underestimate the effect of good documentation.

“When you really get in there and think about the effect of high-quality documentation,” Combs says, “you just keep finding places that it’s impacting.” 💯
Adapt practices for new malnutrition definition

By Richard Pinson, MD, FACP, CCS and Cynthia Tang, RHIA, CCS

The clinical world now has a new set of criteria for malnutrition, thanks to representatives from the American Society for Parenteral and Enteral Nutrition (ASPEN), the European Society for Clinical Nutrition and Metabolism, the Latin American Nutritional Federation, and the Parenteral and Enteral Nutrition Society of Asia who published “Global Leadership Initiative on Malnutrition (GLIM) Criteria for the Diagnosis of Malnutrition: A Consensus Report From the Global Clinical Nutrition Community,” on September 2, in the Journal of Parenteral and Enteral Nutrition.

The GLIM definition of malnutrition is based on five diagnostic criteria: three phenotypic (clinical findings) and two etiologic (causes). The diagnosis of malnutrition requires at least one phenotypic criterion and one etiologic criterion, according to the new criteria (see below).

Under the new criteria, severity of malnutrition is based on phenotypic criteria only, and requires one phenotypic criterion that meets these thresholds (see the table on p. 16.)

The GLIM criteria offer some advantages over the 2012 ASPEN malnutrition consensus criteria. While the ASPEN criteria are effective for diagnosing malnutrition, they are less effective for defining severe malnutrition. The GLIM criteria are less subjective and more clinically intuitive, and they include weight loss, muscle mass, and BMI parameters that are more consistent with the traditional concepts of non-severe and severe malnutrition.

For example, muscle mass assessment is much more robust than in ASPEN, recommending calf/arm circumference, physical findings, and measurement of hand grip strength. Having more stringent criteria for

GLIM MALNUTRITION CRITERIA

<table>
<thead>
<tr>
<th>Phenotypic Criteria</th>
<th>Etiologic Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Weight loss % (unintended)</strong></td>
<td><strong>1. Reduced nutritional intake</strong></td>
</tr>
<tr>
<td>5% &lt; 6 months, or 10% &gt; 6 months</td>
<td>&lt; 50% of requirement &gt; 1 week, or any reduction &gt; 2 weeks, or chronic GI disorders with adverse nutrition impact</td>
</tr>
<tr>
<td><strong>2. Low body mass index (BMI)</strong></td>
<td><strong>2. Inflammation</strong></td>
</tr>
<tr>
<td>&lt; 20 if &lt; 70 yrs, or &lt; 22 if &gt; 70 yrs</td>
<td>Chronic disease, or acute disease/injury with severe systemic inflammation, or socioeconomic/environmental starvation</td>
</tr>
<tr>
<td><strong>3. Reduced muscle mass</strong></td>
<td><strong>Reduced by objective measures and/or physical exam</strong></td>
</tr>
</tbody>
</table>
severe malnutrition reduces overdiagnosis and compliance exposure.

In addition, the GLIM etiologic criteria for acute disease/injury include confirmation of severe systemic inflammation (in contrast to ASPEN). This is a much-needed provision that incorporates recent research on systemic inflammation’s central role in the development of malnutrition. Biomarkers are recommended to confirm chronic or severe systemic inflammation. C-reactive protein (CRP) is preferred, but low albumin/prealbumin are also included. While not specifically mentioned by GLIM, systemic inflammatory response syndrome criteria could also be used to identify systemic inflammation.

Applying the GLIM BMI criteria in the United States could be problematic, however. A sizeable proportion of the population is obese to begin with, so some patients with malnutrition can be expected to have a BMI above 22. A BMI less than 20–22 may be unacceptable for malnutrition when the Centers for Disease Control definition of normal is 18.5 to 24.9. Facilities should consider modifying the GLIM BMI criteria for moderate (stage 1) malnutrition to less than 18.5 and severe (stage 2) to less than 16 to be more consistent with clinical expectations and for compliance purposes.

From a coding perspective, GLIM identifies only moderate and severe malnutrition. Malnutrition stage is not an indexed term, so if stage 1 is documented, code E46 (unspecified malnutrition) may be used. If only stage 2 is documented, it must be clarified as severe for correct coding of E43 (severe malnutrition).

**Editor’s note:** This article originally appeared on Pinson and Tang’s website, [www.pinsonandtang.com/resources](http://www.pinsonandtang.com/resources). Pinson and Tang are the authors of the *2019 CDI Pocket Guide* and the new *Outpatient CDI Pocket Guide: Focusing on HCCs*.

### Moderate (stage 1) malnutrition | Severe (stage 2) malnutrition

| 1. Weight loss % (unintended) | 5%—10% < 6 months, or 10%—20% > 6 months | > 10% < 6 months, or > 20% > 6 months |
| 2. Low BMI | < 20 if < 70 yrs, or < 22 if > 70 yrs | < 18.5 if < 70 yrs, or < 20 if > 70 yrs |
| 3. Reduced muscle mass | Mild-to-moderate deficit (per validated assessment methods*) | Severe deficit (per validated assessment methods*) |

*To measure muscle mass, GLIM recommends use of dual-energy x-ray absorptiometry (DEXA), bio-electrical impedance analysis (BIA), ultrasound, CT or MRI, but these are costly and impractical. As an alternative, calf or arm circumference and physical exam findings may be used along with calibrated hand-grip strength that is correlated with muscle mass.
Mortality reviews and publicly reported quality data

When a patient comes into the hospital and, despite the medical staff’s best efforts, dies, the documentation in the record should accurately reflect how truly sick the patient was. Unfortunately, the record frequently depicts a more-or-less healthy patient who came into the hospital and then died instead of being discharged alive.

While limited documentation results in less accurate code assignment and potentially less reimbursement, it also results in lower facility and physician quality ratings.

Luckily, CDI professionals can improve this situation via the retrospective mortality review process. This type of review often takes place after coding, but before billing, allowing the CDI specialist to compare the documentation in the record to the coded story that’s going out the door to the payer.

Mortality reviews should be done relatively quickly after the patient dies to ensure that all the patient’s complications and comorbid conditions are accurately captured before the claim is filed. However, discussing these reviews with physicians can be a touchy subject—a patient’s death is often emotional for physicians, too, none of whom want to see any of their patients pass away.

Because the situation is a delicate one, CDI professionals need to know the value of these reviews, how to communicate that value to physicians dealing with difficult situations, and the best methods for getting the job done in a timely and tactful manner.

Mortality score methodology

A few fairly common methods for calculating mortality scores exist, including 3M’s APR-DRG severity of illness (SOI)/risk of mortality (ROM) scores and the Vizient mortality index.

The APR-DRG model gives patients SOI/ROM scores from 1 to 4 based on a number of factors, including their principal diagnosis, comorbid conditions, age, and sex. A score of 1 is given to patients posing the least risk, and 4 is applied to the sickest-of-the-sick patients. The SOI/ROM scores are based on the final DRG assigned during the coding process.
“Looking at mortality cases for SOI/ROM is where a lot of facilities start because it’s easy, and everyone pretty much has access to an encoder now so you can see whether the patient came in at a 4/4 or lower,” says Allison Clerval, RN, BSN, CCDS, CDIP, CRC, vice president of clinical and quality services at Intellis, based in the greater Philadelphia area. “It’s kind of an easy lens to look through with CDI.”

Because the SOI/ROM scores are fairly simple to understand and capture, programs wishing to expand to mortality reviews can start with any mortality charts that don’t have an SOI/ROM score of 4/4. This will highlight the extent of the problem for your facility and identify what sort of education is needed, Clerval says.

Another common methodology for mortality scores in academic medical centers that participate with Vizient (formerly University HealthSystem Consortium, or UHC) is Vizient’s own mortality index. Rather than using the patient’s final DRG, the Vizient scores are calculated based on all the conditions that were present on admission only.

“Most diagnoses that developed after admission don’t affect Vizient scores,” Clerval says, since the methodology does not incorporate avoidable or unavoidable conditions that develop after admission. So the review process is more about making the record as complete and accurate from start to finish as possible so the mortality scores correspond to the patient’s actual severity and risk, she says.

Mortality reviews can drastically affect the accuracy of quality scores, regardless of the scoring method used, as CDI reviews on some cases may illuminate an actual performance improvement opportunity for the organization.

“Mortality scoring, if used properly, can help with the cost and the quality of care,” says Pamela Hess, MA, RHIA, CDIP, CCS, CPC, vice president of strategy and operations at MedASTUTE Consulting, LLC, in Phoenix, Arizona.

**Mortality reviews and publicly reported data**

Not only does CMS use mortality data to financially penalize and reward organizations under the Hospital Value-Based Purchasing Program, but private data mining companies pull MedPAR data related to hospitals’ mortality scores and then employ their own algorithms to compare one facility, or one physician, to another.

“Using the various quality systems and implementing them into the clinical medicine is great,” Hess says. “The other thing that’s important is the marketing side of things. Mortality scores are out there on the internet.”

These data sites are often free and open to the public, which means scores are easily accessible by potential patients. If Hospital A’s patients appear healthier than Hospital B’s down the street, but Hospital A’s patients are also more likely to die once they’re admitted, prospective patients will likely choose Hospital B for their care since they’ll perceive they have a better chance of survival there.

But, since the mortality scores are all based on documentation, the disparity could be due to lackluster documentation at Hospital A rather than a real difference in quality between the two facilities.

“Hospital reporting data is out there for everyone to review. Patients are treated more like consumers now,” says Aimee Van Balen, RN, BSN, CCDS, senior clinical documentation specialist at Lifespan in Providence, Rhode Island. “If you’re savvy and trying to pick a place for an elective surgery, for example, and you see that facility has bad mortality scores, you’ll think twice about going there.”

CDI, according to Clerval, can help get to the bottom of those issues by attending facility mortality review meetings. Adding the CDI perspective to the mix can help determine whether a problem is a true quality concern, linked to a coding error, or tied to incomplete or inaccurate documentation.

“If we’re looking at publicly reported data, then everyone at these mortality meetings needs to be looking at the coding,” Clerval says.
says. “Traditionally, coding has gotten blamed for bad quality scores, but I’ve found it very helpful to have CDI at the table to be the bridge between the clinical and coding languages.”

Implementing a successful mortality review process

Ideally, the person conducting a mortality review should not be the same person who conducted the original concurrent review, Clerval says. “It’s nice to have a second set of eyes on it,” she says, but “the real challenge tends to be the staffing logistics, and having enough people to do your concurrent work and all the other things facilities tend to ask for CDI’s help with can be a real stumbling block.”

The more education CDI can bring forward about the importance of mortality reviews, the more resources will likely be made available for the process.

Since mortality reviews are by nature retrospective, Van Balen also suggests reviewing the case after the coding team has taken a first pass at it, which may also mean that a CDI professional has already reviewed it concurrently.

“If there’s no query opportunity, sometimes it’s as simple as adding a missed POA [present on admission] status,” she says. “The coders own the final bill, so what they say is the end story unless you [review retrospectively].”

CDI programs should first conduct a pilot project regarding mortality. Do the research and see what public reporting sites such as the Leapfrog Group, U.S. News and World Report, Hospital Compare, and others show about the facility and its physicians. Next, conduct an audit of all mortality cases within the past quarter to assess any records where the patient expired but the SOI/ROM did not rise to a 4/4. Then determine what documentation disconnects may have occurred and trend the results. Were there an excessive number of cases related to trauma, heart failure, or sepsis? Could documentation concerns be related to changing clinical or coding guidelines of a particular diagnosis, which made it difficult to capture the appropriate documentation or code assignment at the time of death?

Doing this initial review will bring up some points for improvement and provide the CDI team with a place to start its education and review efforts.

While the process Van Balen lays out makes for natural collaboration with the coding team, Hess recommends that CDI professionals also reach out even further for collaboration.

“It’s so important to break down silos. That’s one of my get-on-the-soapbox issues,” Hess says. “It’s important for quality, CDI, and HIM to all work together. If the information isn’t correct in the record, then it won’t be coded correctly, and the mortality scores will be inaccurate. Get the three teams together and get to the root cause of the issue.”

It shouldn’t be difficult to engage with quality on mortality reviews either, Clerval says. “It’s their data as well, and they’re very invested in making sure the data is accurate,” she says.

Throughout the reviews, Hess says, more areas for collaboration beyond the usual suspects may also present themselves. For example, pay attention to how physicians enter information into the EHR, she suggests.

“You may even find out that the problem is arising from a template in the EHR that physicians aren’t using correctly or are confused by,” she says. “It could be an informatics issue, so bring them to the table, too.”

Ultimately, the data belongs to the physicians; mortality scores and publicly reported data reflect on the care they provided. So be sure to include physicians in any mortality review processes, Clerval adds.

“It’s their publicly reported data, and nobody wants to hear that it looks like their patient who died shouldn’t have died,” she says.

In the long run, though the process of mortality reviews is complex and involves many departments, the exercise will improve the hospital’s mortality and quality scores, Van Balen says.

“[These reviews are] a lot of work, but there’s so much value in it,” she says. “Your hospital quality data is discoverable everywhere.”
Principal diagnosis and “most invasive” procedures

Q: Our coders often select the principal diagnosis based on how invasive the testing is. For example, a patient comes in with vertigo and hematemesis. For the vertigo, the physician orders a brain CT, IV medications, and an ear, nose, and throat consult. The patient is diagnosed with a perilymphatic fistula. For the hematemesis, the physician orders a gastroenterology (GI) consult, IV medications, serial hemoglobin and hematocrit (H/H), and an esophagogastroduodenoscopy (EGD) (mild gastritis found). The physician stated there was no source found for the bleeding.

The coder selected the hematemesis as the principal diagnosis because an EGD was done and it was the “more invasive” procedure. The CDI specialist selected the perilymphatic fistula because it was a higher DRG and felt both conditions were what occasioned the admission to the hospital. In this kind of case, the procedure does not drive the DRG.

Has anyone else heard of their coders using this thought process? How would you handle this?

A: There is no simple answer here, unfortunately. The clinical truth lies wrapped up in the Uniform Hospital Discharge Data Set (UHDDS) definition for principal diagnosis: “The condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.” This is what you’re looking for when assigning a principal diagnosis.

As far as I am aware, there isn’t a coding rule that requires the coder to select the principal diagnosis that corresponds to the most invasive procedure. However, it looks like the code selection may still be incorrect in the scenario described. If the EGD found gastritis and the patient had hematemesis, then gastritis with hemorrhage would be the principal diagnosis (as long as it was clear that gastritis, and not some other concurrent GI diagnosis, was responsible for the presentation).

The Indexing in ICD-10 is pretty clear:

- Gastritis
  - With bleeding: K29.71 (Gastritis unspecified with bleeding).

You could query for acute versus chronic if you wanted an even better code. And, under the new Official Guidelines for Coding and Reporting, the physician doesn’t need to say the bleeding was from the gastritis as long as there isn’t documentation in the record to indicate an alternate cause of the bleeding.

All that is to say the coder should likely not be selecting hematemesis as the principal diagnosis. According to the Official Guidelines: “Codes for symptoms, signs and ill-defined conditions are not to be used as the principal diagnosis when a related definitive diagnosis has been established.” Although K92.0, hematemesis, is not a Chapter 18 code, it is functioning here as an ad-hoc symptom that would be included in K29.71.

Another basic coding guideline is to code to the highest level of specificity available, and the K92 category is an “other category,” while K29.71 is the specific diagnosis. You should only use “other” categories when the documentation lacks the specificity to allow for a more specific diagnosis, and in this case, ICD-10 does provide a more specific option.

By the way, the source of the bleeding doesn’t have to be present on the EGD to report the code. Take a look at AHA Coding Clinic, Third Quarter 2017, p. 27:

A patient presents due to acute GI bleed. An EGD was performed, which showed gastric ulcers. The physician does not link the bleeding to the ulcer nor is it documented that these conditions are unrelated. May we assume a relationship between the gastrointestinal bleed and the ulcer. How should
we report gastric ulcer in a patient with gastrointestinal bleeding?

Answer:

It would be appropriate to assign code K25.4, Chronic or unspecified gastric ulcer with hemorrhage. As stated in the ICD-10-CM Official Guidelines for Coding and Reporting, (I.A.15)

The classification presumes a causal relationship between the two conditions linked by these terms in the Alphabetic Index or Tabular List. Unless the provider documents a different cause of the bleeding or states that the conditions are unrelated, it is appropriate to assign the combination code for these conditions.

Since that is true for an ulcer with bleeding, based on the “with” guideline, I don’t see why it wouldn’t also be true for gastritis with bleeding. (The indexing procedure in an ICD-10 manual works the same for either case.)

Bear in mind that there is a logic to this, as mild gastritis often will not yield an exact identification of the site of bleeding on EGD.

Lack of a specific source is a finding routinely associated with bleeding chronic gastritis. You could query for the provider’s confirmation (and perhaps you should), but if there is no other suspected source of the bleeding, then the clinical truth is that it probably was the mild gastritis. This forms the basis of a sound query for linkage between two conditions.

With all that being said, though, I am still not convinced that the GI diagnosis had to be principal diagnosis here. It would come down to the question of the provider’s biggest concern at the time the order was written. Was it the vertigo or the hematemesis? I believe either could work under the UHDDS definition at the time of the admission.

One last thing. The coding professional may be using this section in the 2017 Official Guidelines:

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.

Notice it says “diagnostic workup and/or therapy” as part of the criteria for selection of the principal diagnosis. The coder may be stating that, since the therapy is not equal, the definition of “circumstances of admission” are not equal; therefore, the “two or more conditions equally meeting” rule of coding is not at play and the GI diagnosis supersedes.

I have seen my fellow coders employ this logic many times. Sometimes I agree with them, sometimes I do not. Sometimes it is overruled by other guidelines. For example, if the original treatment plan was not carried out, the Official Guidelines, Section 2.F, p. 104, says:

Sequence as the principal diagnosis the condition, which after study occasioned the admission to the hospital, even though treatment may not have been carried out due to unforeseen circumstances.

This means that the circumstances of admission are more important than the treatments provided. You also have to dig into the timing. Since “circumstances of admission” are what govern the condition that chiefly “occasioned the admission,” you should not be looking much past 24 hours into the stay for your “diagnostic therapy or treatment provided.”

Diagnostic tests and treatments provided outside of that time frame can hardly be counted as part of the circumstances that caused the admission. Some people will point to diagnostic tests or procedures done three or more days into the admission as proof that the two admitting conditions were not co-equal. I disagree with them. Going that deep into the stay is clearly not in accordance with the UHDDS time period of “circumstances of admission.”

Hopefully I’ve given you some things to think about.

Editor’s note: Allen Frady, RN, BSN, CCDS, CCS, CRC, CDI education specialist for HCPro in Middleton, Massachusetts, answered this question on the ACDIS Forum. Contact him at AFrady@hcpro.com. For information regarding CDI Boot Camps, click here. To learn how to get involved on the ACDIS Forum and get your questions answered, click here.
Sepsis: A dysregulated host response to infection

By Cesar M. Limjoco, MD

Sepsis has been defined as a toxic response to infection. Sepsis-1 and Sepsis-2 defined it as a systemic inflammatory response to infection. Sepsis-3 now defines it as life-threatening organ dysfunction caused by a dysregulated host response to infection. These definitions are consistent with the fundamental pathophysiology of sepsis: the immune system going awry in the face of an infection.

Historically, it was thought that sepsis was bacteria in the bloodstream; however, the same bacteria can also be seen in non-septic patients’ blood. Transient bacteremia is regularly seen in patients who are not sick. Procedures that involve instrumentation (e.g., tooth drilling, urethral catheterization, rectal probing) can cause transient bacteremia, as can pneumonias, acute pyelonephritis, ascending cholangitis, bacterial endocarditis, and other localized infections.

It is not the bacteria in the bloodstream that defines sepsis, but the uncontrolled response of the immune system. In fact, sepsis occurs even when bacteria are not seen in the bloodstream. The immune system gone toxic causes circulatory insult and deficiency to the vital organs, causing ischemia, then organ dysfunction, and finally organ failure. This dysregulated host response to infection manifested as organ dysfunction or failure is sepsis/severe sepsis.

So, in order to determine if a patient’s localized infection has developed into sepsis, look for signs of organ dysfunction that cannot be explained by some other condition.

What’s the difference between organ dysfunction and organ failure?

Many providers do not distinguish between organ dysfunction and organ failure, but there is a finite line where dysfunction reaches a point that the organ becomes unable to perform its unique function of supporting the body. Organ failure is organ dysfunction with parenchymal injury. Every vital organ has its tipping point, and when it’s reached, the organ sends signals manifested as signs and symptoms and corresponding abnormal lab values. If you’d like more details, read my previous article on this topic for a deeper dive.

For example, renal dysfunction first manifests as an insufficiency demonstrated by a rising creatinine. Clinical studies have shown that when creatinine rises to 1.5 times its baseline value, the kidney is now in failure. The caveat, though, is that in small rises of creatinine caused by hypovolemia, hemoconcentration falsely manifests as a mild creatinine bump. Although creatinine has not increased, the fluid deficiency makes it look like it has.

Studies have shown that with volume replacement, creatinine values return to normal within six hours and no injury to the kidneys has occurred. But, true acute kidney injury in the same scenario can happen and becomes evident when volume replacement is not able to correct the creatinine bump in six hours. Damage to the renal parenchyma has occurred at that point.

Does life threatening organ dysfunction equate to organ failure?

In the Sepsis-3 definition, “life-threatening organ dysfunction” is intended to differentiate between organ dysfunctions manifested as remediable changes in body temperature, heart rate, and respiratory rate from the more deleterious manifestations, as in hypotension that can lead to septic shock. Is the abnormal procalcitonin or lactic acidosis signaling systemic ischemia, or could it be caused by something else?

The answer may not be evident right away. One needs to consider the overall picture, patient course, and response to interventions in order to unravel the conundrum.
What differentiates sepsis from severe sepsis?

When an organ crosses the threshold from dysfunction to failure, the patient is now in severe sepsis. Each vital organ has its respective functions and corresponding severity thresholds.

In the respiratory system, hypoxemia becomes acute respiratory failure as manifested by a partial pressure of oxygen in arterial blood (PaO2) less than 60 or PaCO2 greater than 50 with a pH less than 7.35 and other equivalent measurements. In the circulatory system, when the mean arterial pressure (MAP = \[(2 \times \text{diastolic}) + \text{systolic}\] divided by 3) is less than 65 with corresponding physical signs (e.g., cool, clammy skin; pale skin or cyanosis; rapid, shallow breathing; dizziness or faintness; weakness), the hypotension has reached the threshold of septic shock.

Hence, it is crucial to delineate when the immune system goes from appropriately fighting an infection to becoming self-destructive. The appropriate inflammatory response may consist of a buildup of inflammatory activity and increased basal metabolic rate. Leukocytosis and fever are part and parcel of a normal inflammatory response. (Caveat: In certain circumstances, especially in the very young and the very old, there will be a paucity of inflammatory activity. Leukopenia and hypothermia may be what manifest instead.)

At its zenith, the dysregulated host response is epitomized by the two opposing forces of hyper-inflammatory response (systemic inflammatory response syndrome [SIRS]) and compensatory anti-inflammatory response (CARS). SIRS is the toxic pro-inflammatory syndrome that aims to kill infectious organisms by activating the immune system. CARS counters it by deactivating the immune system to restore homeostasis. The toxic response is expressed as organ dysfunction, and at its extreme, organ failure defines sepsis and severe sepsis.

In 1991, Sepsis-1 was the first attempt at attaining consensus criteria to decrease sepsis mortality by finding early warning signals commonly seen in critically ill patients. But soon, it became apparent that using Sepsis-1 as a screening protocol brought a lot of false positives. The 2001 Sepsis-2 criteria stated that other variables need to be considered. It expanded the diagnostic criteria to acknowledge the importance of the provider who is actively taking care of the patient.

Source: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4968574/figure/F1/
and included other clinical and laboratory parameters (e.g., creatinine, procalcitonin, lactatemia [lactic acidosis], arterial hypoxemia).

Still, the confusion in the industry persisted. The 2016 Sepsis-3 criteria recognized the limitations in both Sepsis-1 and Sepsis-2 and moved toward quick sequential organ failure assessment (qSOFA) and SOFA as the more definitive criteria. The included diagram from the Journal of the American Medical Association (JAMA) on the Sepsis-3 criteria elucidates the critical pathway to follow in using qSOFA and SOFA in cadence to confirm sepsis. The qSOFA serves as the initial, quick bedside assessment, and the SOFA serves as the confirmatory screening six hours and more.

The pathway jumps from sepsis to septic shock because SOFA variables span the spectrum from sepsis to severe sepsis. It only takes a SOFA of at least 2 to define sepsis, and may have not reached organ failure threshold in the six systems captured in SOFA (respiration, coagulation, liver, cardiovascular, central nervous system [CNS], and renal). See the included table. For example, a patient suspected of sepsis may have a CNS Glasgow Coma Scale score of 14 and a creatinine of 1.2. These variables add up to a SOFA score of 2, satisfying the requirement for sepsis, but neither the CNS or the renal assessment meets the criteria for organ failure yet.

In the end, remember the adage from William Burton Cameron: “Not everything that can be counted counts. Not everything that counts can be counted.” As everyone knows, medicine is both art and science. Definition, criteria, and protocols are attempts to ascertain that which is not black and white. Ultimately, it’s about the Clinical Truth™. To determine the patient’s true condition, the provider considers the patient’s unique circumstances and weaves together an assessment and a work plan that evolves as events unfold. The patient narrative has to show the big picture after study.

Editor’s Note: Limjoco is the chief medical officer for T-Medicus, LLC, based in Las Vegas. He has more than 25 years of consulting experience. Opinions expressed are that of the author and do not necessarily represent HCPro, ACDIS, or any of its subsidiaries. Contact him at dr_cesar_limjoco@me.com.

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Source: [https://jamanetwork.com/dataJournals/JAMA/835012/jsc160002t1.png](https://jamanetwork.com/dataJournals/JAMA/835012/jsc160002t1.png)
Make your voice heard: Submit to Coding Clinic

Rules governing code assignment often don’t make sense to those coming to CDI from the clinical side of the house. In truth, they often confound professionals with years of HIM/coding experience, too. And most CDI and coding professionals have a list of frustrations when it comes to translating clinical documentation into ICD-10 codes.

While CDI and coding professionals may chafe at seemingly antiquated rules and terminology or limited interpretation, it is important to remember the speed at which the governing bodies process and update the code set is delayed in comparison to the speed at which medical terminology and technology change. CDI and coding professionals can make a difference, though: by sending feedback to the organizations responsible for writing coding guidance.

That’s exactly what the CDI team at CentraCare Health—St. Cloud Hospital in Minnesota does. When a frustrating problem arises and there’s no clear answer, Lorene Swenson, RHIT, clinical data reimbursement technician, sets to work on formulating a question to send to those governing code assignment and the rules that CDI and coders need to follow.

The four groups responsible for governing the code set—known collectively as the four Cooperating Parties—include the American Health Information Management Association (AHIMA), the American Hospital Association (AHA), CMS, and the National Center for Health Statistics.

Appropriate code assignment depends on following the hierarchy of authority present in coding rules and guidelines. Coding professionals first look at the Alphabetic Index, followed by rules in the Tabular List and the Official Guidelines for Coding and Reporting. Finally, quarterly releases of the AHA’s Coding Clinic provide insight into how to apply those rules; many private and governmental agencies cite Coding Clinic recommendations in payment and denial considerations.

“Coding Clinic can’t change the index or the instructional notes or anything, but I’m hoping that sending those questions will cause them to go back to the Coordination and Maintenance Committee with those issues,” says Swenson.

Every spring and fall, the Coordination and Maintenance Committee meets to discuss proposed changes to ICD-10. The Committee discusses in detail the background behind the proposed changes and allows comments and questions.
from meeting participants to flesh out the conversation. The questions submitted to and published in Coding Clinic can drive change at these meetings if they present a compelling case.

However, crafting questions, and even knowing what questions to ask, can be a challenge. Sending a constructive query to Coding Clinic requires well-versed knowledge of coding applications, the ability to vet and prioritize concerns, and the creation of a clear and concise request for additional information.

Sometimes, important questions arise from conversations between the CDI and coding teams, says AnneMarie Vannurden, RN, CDI specialist at CentraCare, who explains that monthly joint team meetings allow the staff to raise concerns, “digest them, and bring them [forward] to send in.”

Swenson serves as central coordinator for these concerns. “If I come across something or a CDI staff member comes across something that seems illogical, they send it to me and we try to find a good case scenario to submit to Coding Clinic,” she says.

Vannurden calls Swenson a perfect fit for the job since she’s been in the coding world for more than 30 years, has extensive knowledge of the clinical side of CDI, and serves as the liaison between the two departments. Additionally, Swenson’s years of experience coding charts have given her a deep understanding of medical documentation and clinical conditions.

“Having this skill set has been extremely beneficial in tying together the clinical and coding world to submit the questions to Coding Clinic,” says Vannurden.

While CDI bridges the gap between the clinical and coding side of things, writing questions for submission to Coding Clinic requires an intimate understanding of both sides of the house in order to make a solid case, Swenson says. “I think you have to have a lot of experience and understanding of the coding guidelines and all the nuances of the instructional notes and the clinical indicators—why else would you send a question in the first place?” she says.

While CentraCare may have a “running list of questions” they’d like to send in, Swenson prioritizes those with the most far-reaching implications and a greater probability of changing coding rules.

“We send questions to Coding Clinic [when] there isn’t any clear guidance in the Index or instructional notes [in the Tabular List], especially when the guidance is confusing,” says Swenson, but using that criteria could lead to a never-ending list of questions to be submitted.

“I have to be selective,” she says. “I want to change things, so the most important questions to ask are the ones that I hope will change the Index/Tabular List down the line.”

For example, Swenson sent in a question in early 2017 related to the “with” guidelines. Her question asked whether, when “with” appears anywhere in the Index (e.g., located under a sub-term), the conditions following section I.A.15 of the Official Guidelines for Coding and Reporting could be assumed as related without provider linkage (e.g., duodenal and gastric ulcer and gastrointestinal bleed).

The question was sent to the Coding Clinic Editorial Advisory Board to review, and it was ultimately published in Coding Clinic, Third Quarter 2017, p. 27; the fiscal year 2019 Official Guidelines for Coding and Reporting I.A.15 was also updated to include Coding Clinic’s answer.

CentraCare also looks for data trends, examining denials for repeat concerns. “If I get a denial that does not follow my understanding of coding guidelines or an auditor is looking at something incorrectly, I’ll send that in to Coding Clinic,” she says. “Recently, a lot of the questions we sent were about encephalopathy and how it’s integral to other conditions. We have a lot more scrutiny from outside agencies nowadays.”

Because of the scrutiny, CentraCare sent in a question to Coding Clinic in 2016 asking whether encephalopathy would be integral to a stroke in a patient with encephalopathy who was admitted with a cerebrovascular accident.

In return, CentraCare received a response letter instructing their coding professionals to assign the code for encephalopathy, unspecified, for encephalopathy
that occurs secondary to an acute stroke. Even though the encephalopathy is associated with an acute lacunar infarct, Coding Clinic said, it’s not inherent and therefore it should be coded when it occurs.

The question and answer were ultimately published in Coding Clinic, Second Quarter 2017, p. 9.

**Know your stuff, make a solid case**

Once you’ve chosen your battle, spend some time putting your arsenal together by including a case example that supports the need for an answer (minus any identifying patient information, of course). It’s important to send only questions that are well-researched and thought out. Otherwise, you may not get a detailed response to the question, or the answer won’t be published in Coding Clinic.

While Coding Clinic’s editorial board may provide facilities with direct responses to their questions, they typically indicate that such responses should not be shared publicly. Coding Clinic publishes certain globally indicative questions and answers on a quarterly basis.

Many software vendors include Coding Clinic subscriptions in their packages, but otherwise CDI programs should obtain a subscription themselves, work with the HIM/coding teams to review Coding Clinic publications, and look to CDI Journal for regular coverage of particularly newsworthy items.

“You really shouldn’t send a question to Coding Clinic unless you feel confident you understand that Index [logic] and why the [Cooperating Parties] would need to revise it,” Swenson says.

**Enlist help**

Ultimately, coding rules and guidelines take a long time to change. Since the Official Guidelines for Coding and Reporting are only updated annually, Coding Clinic advice can be greatly beneficial in the meantime.

Effecting change will take more than one questioner’s efforts, too. CDI professionals shouldn’t simply rely on the vocal few to send in questions; they should be sending in their own questions and discussing their difficulties with each other to present a united front to Coding Clinic.

Think how much more effective it would be for Coding Clinic to get several questions on a topic rather than just one question that could be an isolated incident, Vannurden says.

While ACDIS has recently formed a Regulatory Committee, in part to send in questions that are plaguing the CDI and coding worlds, individual organizations should do the same wherever they’re able and see fit to do so. “Some of these things have been a thorn in the side of CDI and coding for a long time,” says Vannurden.

So, if you’re running into an issue regularly, talk to others in the field, whether at a local chapter meeting, on the ACDIS Forum, or in person, to find out if they struggle with the same issue. Then, coordinate your efforts to submit questions. You’re much more likely to get answers that way, according to Swenson.

“We all have to lean into the center,” she says. “We have to be willing to work together.” 💪

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**HOW TO SUBMIT QUESTIONS TO CODING CLINIC**

So, you have a question and you’ve done your research to put together a submission to Coding Clinic. Now what? Questions can be submitted to Coding Clinic any time; they don’t have to correspond to a quarterly publication.

While you do need to create a login for the website, anyone can submit a question to Coding Clinic by visiting their site and clicking on the “Submit a question” link.

With a few exceptions, all questions do receive answers, though not all questions are published in the quarterly publications. Each question is assigned a tracking code so that the submitter can track its progress.

To read more about the dos and don’ts of question submission, visit the Coding Clinic website.
CODING CLINIC FOR CDI

Third quarter tackles issues diabetes and more

By Sharme Brodie, RN, CCDS

I’m glad I’m not the only one who sometimes has a problem determining the proper codes and their proper sequence. I also must not be the only person out there who has questions about coding diabetes, it turns out, because the Third Quarter 2018 edition of Coding Clinic answered a few questions on that subject plus many more.

On p. 3, Coding Clinic discusses a patient with a gangrenous stage 3 pressure ulcer of the heel who also had diabetes. In the situation described, the gangrene was related to the pressure ulcer of the heel, which was not a diabetic foot ulcer. For this case, ICD-10-CM instructs to code first any associated gangrene. In this situation, the primary reason for the admission was for treatment of the gangrenous pressure ulcer.

Diabetic ulcers typically involve the foot, starting on the toes and moving upward. Pressure ulcers typically develop in tissue near bony prominences, such as the elbows, tailbone, greater trochanters, or heels.

Although diabetes mellitus may increase the risk of pressure ulcers because of its association with neuropathy and angiopathy, ICD-10-CM does not classify pressure ulcers the same way as diabetic ulcers. The classification does not provide index entries for diabetes with pressure ulcer, as the code categories for diabetes were not intended to describe pressure ulcers. In addition, Coding Clinic advises to assign codes E11.51, Type 2 diabetes mellitus with diabetic peripheral angiopathy with gangrene, and E11.40, Type 2 diabetes mellitus with neurological complications, as additional diagnoses.

Diabetes with arteriosclerotic peripheral artery disease

The scenario on p. 4 describes a diabetic patient with arteriosclerotic peripheral artery disease. The question asks whether an additional code should be used from subcategory I70.2-. Atherosclerosis of native arteries of extremities, to describe the affected vessel and laterality. Coding Clinic answers that code E11.51, Type 2 diabetes mellitus with diabetic peripheral angiopathy with gangrene, along with an additional code from subcategory I70.2-, should be assigned to fully capture the patient’s condition when the documentation provides specificity about the atherosclerosis such as laterality, affected vessel, or additional manifestations of the disease.

According to the Official Guidelines for Coding and Reporting (1.B.9),

Multiple coding should not be used when the classification provides a combination code that clearly identifies all of the elements documented in the diagnosis. When the combination code lacks necessary specificity in describing the manifestation or complication, an additional code should be used as a secondary code.

Diabetes type 1.5

A scenario on p. 5 talks about a 14-year-old female patient seen in a clinic. The provider documented “combination Type 1 and Type 2 diabetes mellitus in poor control.” The provider was queried and confirmed both Type 1 and Type 2 diabetes. This condition is also called Type 1.5 diabetes. The question asks what the correct diagnosis code would be in this situation.

Coding Clinic states to assign codes from category E13, Other specified diabetes mellitus, for Type 1.5 diabetes mellitus (combined Type 1 and Type 2). In this case, because the provider documented “combination Type 1 and Type 2 diabetes mellitus in poor control,” Coding Clinic instructs to assign code E13.65, other specified diabetes mellitus with hyperglycemia.

Type 1.5 diabetes is a form of diabetes in which an adult has features of both Type 1 and Type 2 diabetes. These patients have also been described with the terms “latent autoimmune diabetes of adults (LADA)” and “slow-progressing Type 1 diabetes.”
The condition has also been called “double” diabetes, because individuals demonstrate both the autoimmune destruction of beta cells characteristic of Type 1 diabetes and the insulin resistance characteristic of Type 2 diabetes. People with Type 1.5 diabetes have auto-antibodies to insulin-producing beta cells and gradually lose their insulin-producing capability, requiring insulin within 5–10 years of diagnosis.

**AMI and chronic total occlusion of the coronary artery**

Page 5 also includes a question about a patient diagnosed with an acute myocardial infarction (AMI) and chronic total occlusion of the coronary artery. This question seeks clarification due to some confusion regarding an Excludes1 note under code I25.82, chronic total occlusion of coronary artery, which excludes “acute coronary occlusion with myocardial infarction (I21.-, I22.-).”

In the end, because these conditions are unrelated, the occlusion and myocardial infarction are in different arteries, so it is acceptable to assign a code for both the AMI and the chronic total occlusion. The Official Guidelines for Coding and Reporting state, “An exception to the Excludes1 definition is the circumstance when the two conditions are unrelated to each other.”

**Chronic atrial fibrillation**

Let’s continue with a question from p. 6. In this scenario, a patient was admitted for treatment of chronic atrial fibrillation (AF) with rapid ventricular response (RVR). In ICD-10, there are codes for paroxysmal, chronic, and persistent AF, but there is no code for AF with RVR. The question says that a diagnosis of chronic AF with RVR seems to indicate severity and asks whether it would be appropriate to assign code I48.0, paroxysmal atrial fibrillation, for AF with RVR.

I was glad to hear this piece of advice from Coding Clinic. They state that code I48.0 is not appropriate since the patient did not have paroxysmal AF. Coding Clinic states to assign code I48.2, chronic atrial fibrillation, for chronic AF with RVR. The RVR is not coded separately. Chronic AF with RVR indicates problems with rate control, not paroxysmal AF.

**Persistent seroma**

Page 6 also includes a question about a persistent seroma that developed at the site of a previous mastectomy. Coding Clinic says to assign code M96.843, postprocedural seroma of a musculoskeletal structure following other procedure, as the breast is no longer present. Seromas usually occur at the mastectomy site on the chest wall following mastectomy and axillary lymph node dissection for breast cancer.

**Lupus**

A question on p. 14 asks for clarification regarding a default code for lupus. In ICD-9, lupus unspecified defaulted to lupus erythematosus (SLE), but this issue of Coding Clinic clarifies that there is no default lupus code in ICD-10-CM; a query is necessary to specify the type of lupus for accurate code assignment.

Many of you might have already known that, but what Coding Clinic goes on to say might surprise you:

“After review of ICD-10 and ICD-11, the World Health Organization has determined that ICD-10 will remain with no default code for lupus not otherwise specified or unspecified lupus. However, hospitals and other healthcare facilities may develop facility-specific guidelines to report code M32.9, Systemic lupus erythematosus, unspecified, as a default for lupus not otherwise specified.”

I could be wrong, but I have not seen hospitals and other healthcare facilities allowed to develop facility-specific guidelines for use of a default code before.

**Of interest**

Page 17 contains some general information that might be of use. Here, Coding Clinic states that drains placed in the operative wound site at the end of a procedure to prevent re-accumulation of fluids are not coded separately. A Penrose drain placed at the end of an open surgical drainage procedure is considered the same as any other temporary postsurgical wound drain to prevent buildup of fluid.

Therefore, guideline B6.1b applies: “Materials such as sutures, ligatures, radiological markers and temporary postoperative wound drains are considered integral to
the performance of a procedure and are not coded as devices.”

On p. 18, Coding Clinic clarifies that ICD-10-PCS does not separately classify periosteal tissue as a body part value; therefore, if coding the debridement of an ulcer including periosteal tissue of the calcaneus (heel bone), assign a code for the debridement of the underlying bone.

GI conditions

On p. 21, Coding Clinic responds to a question about the coding of a gastrointestinal (GI) bleed likely secondary to a small bowel arteriovenous malformation (AVM) with no documentation stating whether the AVM is acquired or congenital. The Index to Diseases directs coders to use code Q27.33, arteriovenous malformation of digestive system vessel. The question asks, “Since an arteriovenous malformation is a vascular ectasia similar to an angiodysplasia, would it be appropriate to assign code K55.21, angiodysplasia of colon with hemorrhage?”

Coding Clinic answers that coding professionals should "assign code K55.21, angiodysplasia of colon with hemorrhage, for the bleeding small bowel AVM, not stated as congenital. Although the index directs the coding professional to a congenital code, according to research, vascular ectasias, such as angiodysplasias and arteriovenous malformations, involving the GI tract typically occur in adults 60 or older, and is a common cause of bleeding in that age group. The etiology is believed to be degenerative in nature rather than congenital.”

Continuing with the GI theme, a question on p. 21 asks whether it is appropriate to assign codes for multiple bleeding sites when more than one finding/possible cause is linked. Coding Clinic states that yes, multiple sites can be coded with bleeding, and either condition can be sequenced as the principal diagnosis. They also remind us that if bleeding is not seen during a colonoscopy, it does not preclude the assignment of a code describing hemorrhage. ICD-10-CM makes a linkage between gastrointestinal hemorrhage and diverticulosis and angiodysplasia; therefore, the provider does not have to link the conditions in the documentation.

Another question asks about a patient who had an esophagogastroduodenoscopy (EGD) performed due to coffee-ground hematemesis. The provider’s final diagnostic statement listed “acute upper gastrointestinal (GI) hemorrhage, ulcerative esophagitis, and duodenitis.” The question asks whether it would be appropriate to assign a combination code for ulcerative esophagitis with bleeding and duodenitis with bleeding, to capture multiple bleeding sites. The answer states that “since the classification links the hemorrhage in both conditions, it is appropriate to assign the combination codes indicating ‘with bleeding.’”

Pneumonia

Lastly, let’s talk about pneumonia. On p. 24, Coding Clinic responds to a question about the coding of physician documentation stating “right upper lobe pneumonia” when the causal organism is not documented. As many of you might have known, the answer is to code J18.1, lobar pneumonia, unspecified organism.

However, when the causal organism is identified, we would use a combination code indicating the specific pneumonia with the responsible organism. If the provider documents that the pneumonia is specific to a lobe, or a similar diagnostic statement for pneumonia affecting one or more lobes of the lung, or part of a lobe, code J18.1 would be assigned when the causal organism is not specified. A diagnosis of “lobar pneumonia” (pneumonia that mentions the affected lobe) or “multilobar pneumonia” (pneumonia affecting more than one lobe) describes the specific site of the pneumonia (rather than a type of pneumonia) and would be coded to the responsible organism, if known.

Any time there’s a localized or systemic infection, a CDI specialist would want to see whether it’s possible to identify the organism (remember, cultures aren’t necessary) and the specific infection site. 💯

Editor’s note: Brodie is a CDI education specialist and CDI Boot Camp instructor for HCPro in Middleton, Massachusetts. For information, contact her at sbrodie@hcpro.com. For information regarding CDI Boot Camps offered by HCPro, click here.
The impact of EHR on Your CDI Efforts

by Trey La Charité, MD, FACP, SFHM, CCS, CCDS

Do you want to see a doctor explode? Just ask about the facility’s electronic health record (EHR) system. I have never heard a practicing clinician say, “I love the EHR.” Most clinicians see the EHR as a bureaucrat-imposed quagmire that has resulted in an increased workload without any perceptible benefit to the patient. However, the EHR is here to stay. Providers need to accept that fact.

While CDI professionals don’t view the EHR quite as apocalyptically, it presents challenges to them as well. Every new technology has workflow and output implications; by reviewing common EHR challenges, a CDI program can formulate appropriate mitigation strategies to minimize the potential negatives.

Note cloning

The most widely recognized effect of the EHR on CDI is the phenomenon of cloning. Cloning occurs when a provider copies most or all of his or her progress note from the previous day and pastes that information into today’s note. The physician’s theory is that yesterday’s entry will stand for today as well, and that this is an acceptable method of saving time, since nothing materially changed in the preceding 24-hour period.

Cloning, however, does not provide sufficient evidence of a new, independent patient care visit to warrant a new, separate evaluation and management code (i.e., a physician daily bill). Therefore, cloning carries substantial fraud implications for the provider if discovered.

For CDI programs, this documentation practice results in a stagnant list of medical problems. The original diagnoses do not evolve or expand to achieve the accuracy and specificity required to ensure an accurate representation of the patient’s current clinical condition. Problem lists should only grow during a hospitalization. Cloning means that no new information about a patient’s clinical situation is furnished.

To combat cloning in our facility, I teach providers that it is OK to copy and paste a problem list (with appropriate updates, clarifications, and the addition of new diagnoses) from assessment to assessment. However, it is never acceptable to copy and paste the care plan. This approach still allows clinicians to save time, but prevents abuse by keeping them within accepted documentation compliance norms.

Note bloat

Note bloat is another notorious byproduct of the EHR’s copy-and-paste functionality. Note bloat occurs when providers copy all (or substantial portions) of other documents, such as radiology or pathology reports, lab results, or consultants’ assessments, into their daily progress notes. While the idea is to be thorough and to prove that a provider reviewed everything germane to the patient, this practice leads to incredibly large and expansive notes. Because no one can determine what information in the note is relevant for that day’s care plan, the note becomes unusable.

CDI specialists and coding professionals also struggle to determine which elements affect the coding of that record. Note bloat creates an informational nightmare for everyone.

Fortunately, note bloat is easily preventable: Simply encourage providers to only restate the final summations of other medical reports in their notes.

Legibility and clarity

A major victory of the EHR is improved legibility; however, physician clarity has not increased. While it’s no longer necessary to spend valuable time deciphering illegible handwriting that could represent either ventricular tachycardia or asystole, we have a new problem: Providers still aren’t always clear in their documentation. “What does that say?” has segued into “Did they really mean to say that?”
Providers must still be explicit in their documentation to ensure the accurate reporting of all disease processes that affect their patients’ care. Please, docs, say exactly what you mean. Unclear documentation is unclear documentation, no matter how legible the letters and words may be.

**Diagnosis-physical exam incongruity**

A newly created problem as a result of the EHR is one that I dub “diagnosis–physical exam incongruity.” In other words, a disconnect exists between the patient’s diagnosis and the physical exam’s description of the clinical presentation.

For example, the admission history and physical might state the patient has “acute respiratory failure” and “acute encephalopathy” in the assessment and plan. However, the accompanying physical exam says the patient is “awake, alert, orientated x 4, and is in no acute distress”; the patient’s lungs are “clear to auscultation bilaterally with normal respirations”; and a neurological exam states the patient has “appropriate mood, affect, and judgment without focal deficits.”

I would argue that a patient cannot have acute respiratory failure and acute encephalopathy together with a “normal” physical exam. So how does this documentation discord arise? It’s simple: the busy clinician simply did not update the prepopulated template for a normal physical exam. While this is an understandable mistake caused by workload and time pressures, providers must not forget to update the physical exam section of their notes. The record must accurately reflect how sick their patients appeared.

Unfortunately, Recovery Auditors are wise to these discrepancies. If discovered, they immediately issue a clinical validation denial, and these denials are very difficult to appeal. For example, we cannot prove a patient had an “acute systolic CHF exacerbation” if the patient did not at least exhibit some jugular venous distension, some rales on lung exam, a third heart sound (S3), some displacement of the point of maximal impulse, or some lower-extremity edema.

Providers must take the time to make their patients appear as sick in the record as they are in reality.

**Alert fatigue**

Another problem created by the EHR and computerized physician order entry is alert fatigue. All practicing clinicians have become desensitized to pop-up alerts, myself included. How have we learned to handle these new messages and warnings? That’s easy: We click through them without hesitation because we have determined that they are irrelevant and a nuisance. More importantly, we have learned that there is no consequence to doing so.

Alerts and pop-ups have become the technological equivalent of “crying wolf.” This may negatively affect your CDI program if your concurrent queries or other CDI communications are delivered as alerts or pop-ups. Your facility runs the risk of the clinician clicking through them without a second glance, thus tanking your query response rate. Providers will never adopt CDI program goals if you cannot capture their attention.

While my hospital’s queries are delivered via our EHR system, they reside outside the actual chart in a separate messaging window. While this still isn’t a perfect delivery system, our providers cannot just click them away without consideration.

**Useful documents in the EHR versus on paper**

Another potential negative EHR impact on your CDI program is that the useful content of the documents created in the EHR may not be equivalent to what was previously provided on paper. Before the EHR, dictation was an extremely efficient documentation tool. All providers had to do was speak into the phone as fast as they could and hang up when they were done, and a perfect document appeared after human transcription. We failed to appreciate how much work the human transcriptionists did in creating those documents. Providers never worried about spelling, grammar, or
punctuation as all those things were cleaned up by the magician on the other end of the phone.

With the advent of the EHR, we fired the transcriptionists and left providers in charge of their language use. The real-time product of our harried thoughts instantly appears on the computer screen, whether we use electronic transcription software or type our notes manually. There’s no longer an intervening professional to correct all of our mistakes.

For many, grammatical errors staring back at them from the computer screen are intolerable, but more time spent editing notes means less time spent on patient care. Many of these providers actually enter less information, or lower-quality information, into the EHR to make up for the time they spend correcting their work.

On the other end of the personality spectrum, some clinicians completely ignore their mistakes and do no editing at all, resulting in documents that are nonsensical or contradictory to their intended meaning. In either case, the content of the EHR document may not be up to the standard we used to have with paper documentation.

**Implementation disasters**

An EHR implementation gone wrong could have a devastating effect on your CDI program. If the change from paper to electronic documentation goes badly, the providers tend to take their frustrations out on all their other hospital-related annoyances.

You cannot risk a bad EHR rollout sabotaging your CDI program’s efforts. Remember that EHR vendors are likely to overpromise and underdeliver, and testimonials about an EHR vendor’s success at a different facility may be completely inapplicable to your own hospital—no two facilities are alike.

To ensure your EHR implementation doesn’t drop a bomb on your CDI initiatives, interview several different facilities where a particular EHR product has recently been installed to find out what went well and what did not. Apply the lessons learned from the successes and failures of others before your EHR go-live date. (To read a recent ACDIS white paper about working with and choosing a software vendor, click here.)

**Query transparency**

The last area of potential risk from the EHR is increased query transparency. An electronic entry can be ferreted out by a dedicated sleuth eventually, regardless of how deeply buried it was in the computer. If your queries are on the brink of being leading or otherwise noncompliant with industry standards, clean them up before moving into the electronic realm. If you don’t, the Office of Inspector General will be happy to slap a fraud charge on your facility to increase its recoupments.

As my mentor says, “The E in ‘email’ stands for evidence.” Therefore, always make sure your CDI program follows the accepted standards for query formulation. In addition, regularly self-audit of your program’s queries to prevent unintentional drifts into trouble.

The EHR is not a perfect solution. However, it is here to stay. Familiarizing yourself with your EHR’s strengths and weaknesses can better equip your CDI program to leverage the positive aspects of electronic documentation and avoid the potential pitfalls. Fortunately, most EHR platforms are customizable to some degree, which gives your CDI program the chance to optimize provider workflow.

Spend time with your providers to see how your CDI program has been woven into their EHR experience. You may develop a new level of appreciation for their daily toils and frustrations. Only then will you be able to advocate for needed improvements that may result in greater documentation veracity and consistency.

Optimizing clinician workflow in the EHR should be a constant objective of the CDI team. Relieve some of providers’ pressure to do more and see more patients by simplifying their day, and clinicians may reward you with the quality documentation you need.

**Editor’s note:** La Charité is a hospitalist at the University of Tennessee Medical Center at Knoxville, a clinical assistant professor, and the medical director of UTMC’s CDI program. He is a past member of the ACDIS Advisory Board and the author of three books. La Charité’s comments and opinions do not reflect necessarily those of UTMC, ACDIS, or its Advisory Board. To reach La Charité, email him at clachari@utmck.edu.
MEET A MEMBER

Professional path includes roles as physician assistant, CDI, consultant, and auditor

Dianne Rodrigue, PA, MHP, CHC, CCDS, CRC, CPC, is a senior manager at Baker Newman Noyes, a public accounting firm based in Portland, Maine, with a healthcare advisory and consulting division. She is also a member of the Maine chapter of ACDIS.

ACDIS: How long have you been in the CDI field?

Rodrigue: I was credentialed as a CCDS in 2014 but have essentially been working in the field since 2012. My role in CDI has always centered on education relative to clinical documentation improvement and integrity, whether that be in support of accurate diagnostic coding in all facility settings, Current Procedural Terminology® and evaluation and management coding, or more recently risk adjustment coding.

With the implementation of ICD-10-CM and the enhanced clinical detail inherent in the code set came a greater emphasis on the documentation in support of the most specific and accurate diagnostic code(s). I can identify that time period as a turning point in my career and in understanding how clinical documentation plays an integral part in the revenue cycle of any healthcare organization.

ACDIS: What did you do before entering CDI?

Rodrigue: Prior to my current role as a revenue cycle consultant and auditor, I worked as a physician assistant in a large teaching hospital. I was part of the cardiac surgery team and spent most of my day in the operating room or the ICU, assisting the physicians. And if you go even further back in time, my first job after college was working as a registered dietitian in the dialysis and renal transplant unit of the hospital.

ACDIS: Why did you get into this line of work?

Rodrigue: I knew from a young age that I would find a career in healthcare. My father is a retired ear, nose, and throat physician, and I witnessed firsthand the immense satisfaction and reward he derived from taking care of patients.

Clinical medicine is challenging and complex, which partially influenced me to become a physician assistant—I always love a challenge. Equally challenging
and complex are the rules and regulations that govern the reimbursement of healthcare services. I deliberately moved away from the clinical side in an effort to better understand how healthcare services are reimbursed.

**ACDIS: What has been your biggest challenge?**

**Rodrigue:** Like so many, balancing the demands of work and family.

**ACDIS: What has been your biggest reward?**

**Rodrigue:** One aspect I always find rewarding is being able to bridge the knowledge gap, particularly for clinicians, as it relates to documentation and coding. This type of education for students and residents seems largely absent or inadequate.

Having clinical insight and an understanding of physicians’ typical activities and workflow is hugely valuable when educating a group of providers on nonclinical topics.

**ACDIS: Can you mention a few of the “gold nuggets” of information you’ve received from colleagues on The Forum or through ACDIS?**

**Rodrigue:** I was a huge fan of Dr. Robert Gold. I once had lunch with him and a group of conference attendees following a local presentation he did on clinical documentation and coding. What stuck with me was his emphasis on clinical documentation integrity—seek “the clinical truth” through documentation and coding, and the appropriate reimbursement will follow. Coding integrity and compliance cannot be separated from CDI.

**ACDIS: If you have attended, how many ACDIS conferences have you been to? What are your favorite memories?**

**Rodrigue:** I’ve attended two ACDIS conferences and am always impressed with the quality of topics and speakers as well as with the passion and enthusiasm of the CDI professionals attending.

**ACDIS: If you could have any other job, what would it be?**

**Rodrigue:** I’ve always wanted to act on the stage, so to be part of a theater company would be exciting. Or, if there was a job as a professional student, that would suit me. I’ve loved every school and formal education program that I’ve been part of and am always looking to enhance my knowledge.

**ACDIS: What was your first job (what you did while in high school)?**

**Rodrigue:** I worked as a carhop at a local drive-in. While I didn’t wear roller skates when delivering the trays of food, I did find the clicker holding the dollars and coins to be incredibly cool at the time.

**ACDIS: Can you tell us about a few of your favorite things?**

- **Vacation spots:** Anywhere with long hours of sunshine; Costa Rica was one of my favorite family trips for the natural beauty of the land and the people.
- **Hobby:** Gardening in the warmer months, skiing in the winter, and yoga year-round to keep me relaxed and grounded.
- **Non-alcoholic beverage:** Vitamin water.
- **Foods:** Anything spicy: Mexican, Thai, etc. The spicier, the better.
- **Activity:** Reading. While I rarely read fiction, I try and read through two newspapers every day—articles unrelated to healthcare.

**ACDIS: Tell us about your family and how you like to spend your time away from CDI.**

**Rodrigue:** I’m married with four children (23, 18, and twins who are 16). And we have two dogs, a golden doodle and a miniature dachshund. All of them keep us busy and entertained.

**Editor’s note:** Are you interested or do you have a colleague who would like to be featured in our “Meet a Member” segment? Contact ACDIS Editor Linnea Archibald at larchibald@acdis.org.