Navigating Documentation and Coding Regulations in Search of Clinical Accuracy

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Learning Objectives

• At the completion of this educational activity, the learner will be able to:
  – Describe common coding mistranslations from clinical language
  – Identify areas of potential documentation improvement in areas generally viewed as controversial and difficult to address
  – Articulate a better understanding of the need for critical analysis of a case prior to issuing a query
  – Identify areas of concern with proper reporting of the clinical truth under the 2019 final rule as well as previous regulatory guidance
  – Identify problematic coding guidance and difficult-to-follow guidelines
  – Identify areas of need for additional education potential for both coding and CDI
Steps for Attendees to Answer/View POLLING QUESTIONS

1. Navigate to the event **Agenda** in the main menu
2. Tap the **name of the current session** to view the session details page
3. Tap **Polls**
4. Tap the **name of the poll**
5. Tap your **answer** choice and then tap **Submit**
Polling Question 1

• How often do you find yourself at odds with the coders due to conflicting coding guidance?
  – Never
  – Rarely
  – Often
  – Very frequently
  – All the time
Why Do Denials Occur?

- Failure to **accurately** follow coding guidelines
- Indexing of the **exact language** used by the provider is **not supported** by the information contained within the medical record
- The **context** of the record does not indicate clinical significance after considering the patient’s **co-existing conditions and baseline** because the **clinical indicators** are either explained by other existing disease states or are not significantly
- Services provided are **non-covered**
- **Contractual** obligations are not met with commercial insurances such as timely notification
- Diagnoses are reported using **different terminology** among various providers
  - “The documentation of encephalopathy conflicting or inconsistently documented throughout record”
Why Do Denials Occur? (cont.)

• Best practice requires the attending physician restate all clinical diagnoses which were monitored, evaluated, or treated within the stay, including those made by OTHER physicians and not just limited to those conditions addressed by the attending him/herself.

• The need for continuing observation beyond 48 hours of a patient and or the potential negative consequences of an early discharge are not stated clearly.
  – Patient safety is a priority.

• Failure to discharge after what the payer calls “maximum medical benefit” of hospitalization has been met (related to above).

• Insurance company’s “home cooked” clinical criteria based on outdated research and practice.

• The treatment of a condition is not prominently featured within the medical record.
  – Although monitoring may require continued stay, payers are often fixated on treatment.
Conflicting Advice From Official Sources

When there is a discrepancy between the conventions in the classification, the guidelines and/or advice published in *Coding Clinic*, coding professionals should adhere to the following hierarchy: Conventions in the ICD-10-CM and ICD-10-PCS classification take precedence over the Official Guidelines for Coding and Reporting, and both the classification and guidelines take precedence over *Coding Clinic* advice.

*Coding Clinic*, Fourth Quarter 2018, p. 90
The Hierarchy of Guidance

If coding professionals feel that published advice is in conflict with coding guidelines or the ICD-10-CM/PCS classification, please submit a specific case example to the AHA Central Office, with potential for submission to the Coding Clinic Editorial Advisory Board for review.
Do You Follow the Hierarchy or Do You Follow Coding Clinic?

• “A patient is diagnosed with acute on chronic gastrointestinal (GI) bleeding, most likely secondary to small bowel arteriovenous malformation (AVM).” The Index to Diseases directs the coding professional to Q27.33, Arteriovenous malformation of digestive system vessel.

• Assign code **K55.21**, Angiodysplasia of **colon** with hemorrhage for AVMs associated with a bleed not stated as congenital. The etiology is believed to be degenerative in nature rather than congenital.
  – Third Quarter 2018, p. 21
Do You Follow the Hierarchy or Do You Follow Coding Clinic?

- “Patient with severe emaciation requiring medical intervention of TPN and long-term planning for insertion of G tube and ongoing tube feeding”
  - ICD-10 index:
    - Emaciation: (Due to malnutrition) E41: Nutritional marasmus
    - Remember: In ICD-10, anything in parenthesis is considered a “non-essential modifier” and unnecessary, right?
    - Coding Clinic, Third Quarter 2017
      - Assign code R64, Cachexia, for a diagnosis of emaciated/emaciation. If the provider intended to describe malnutrition, then it should be documented as such.
  - Better documentation: “Patient with severe protein calorie malnutrition as evidenced by emaciation requiring medical intervention of TPN and long-term planning for insertion of G tube and ongoing tube feeding”
    - ICD-10 code:
      - E43: Unspecified severe protein-calorie malnutrition
Guidance vs. Guidance

2019 Official Coding Guidelines

- 1.B.21.e.4

“BMI codes should only be assigned when the associated diagnosis (such as overweight or obesity) meets the definition of a reportable diagnosis (see Section III, Reporting Additional Diagnoses).”

Coding Clinic, Third Quarter 2011 p. 4

“Individuals who are overweight, obese or morbidly obese are at an increased risk for certain medical conditions when compared to persons of normal weight. Therefore, these conditions are always clinically significant and reportable when documented by the provider.”

According to the above combinations of guidance

1) Obesity and morbid obesity are always reportable as they are always clinically significant
2) BMI is assigned when the associated diagnosis is reportable
3) Conclusion: BMI and obesity are always reportable
Body Habitus and BMI

• Fourth Quarter 2018, p. 78
  – Question: If the provider documents “overweight” in the history and physical and/or discharge summary only, without additional documentation to support the clinical significance of this condition, can it be coded?
  – Answer: No, neither the code for overweight nor the BMI code is assigned if there is no documentation that the diagnosis of “overweight” meets the definition of a reportable secondary diagnosis.

• Fourth Quarter 2018, p. 77
  – “… the provider must provide documentation of a clinical condition, such as overweight, obesity or morbid obesity, to justify reporting a code for the body mass index.”

• Conclusion: “Overweight” will not justify reporting of BMI without additional documentation of the clinical conditions being exacerbated via the body habitus. Both “obesity” and “underweight,” however, are mentioned in Coding Clinic as ALWAYS clinically significant.
Guidance vs. Guidance

• Beware. Auditors will likely claim that OCG 1.B.21.e.4: “Should only be assigned when the associated diagnosis meets the definition of a reportable diagnosis” to mean that obesity and morbidity may NOT in fact always be reported and are not in fact always “clinically significant.”
• Do we start applying the traditional “five rules” to obesity?
• Must we demonstrate in the record that obesity is receiving additional diagnostic testing, therapeutic intervention, diagnostic evaluation, increased nursing services, or increased length of stay?
• Does the “increased risk for certain medical conditions when compared to persons of normal weight” no longer justify reporting obesity without further demonstration of the UHDDS criteria?
• This is very confusing.
Intent vs. Guidance

Quality/bundled payment initiatives assure us that comprehensive coding will allow for the proper risk adjustment related to both predicting and capturing cost in a population management model as opposed to a fee-for-service model in regard to adult patients. However:

Official Coding Guidelines FY 2019 Section C. Coding additional perinatal diagnoses states:
“Code for conditions specified as having implications for future health care needs
Assign codes for conditions that have been specified by the provider as having implications for future health care needs.
Note: This guideline should not be used for adult patients”

If we cannot report adult diagnoses that have implications for future healthcare needs, how are we supposed to excel in risk-adjusted population-based healthcare management and reporting models?

Write to CMS and point this out! This line of thinking seems to be part of the motivation behind AHA and CMS reporting on obesity and tobacco exposure already, i.e., were not immediately addressed but area associated with risk trends. For now this is allowed as these particular examples won’t change a DRG. If a risk-related diagnosis DOES change a or quality metric, however, we run into problems with these seemingly contradicting goals.
“Classic” Coding Problem

• “Patient with a sudden severe and extreme blood loss anemia and a 5 point drop in Hgb, status post transfusion.”
  – ICD-10 code:
    • D50: Iron deficiency anemia secondary to blood loss (chronic)

• “Patient with an acute severe blood loss anemia and a 5 point drop in Hgb, status post transfusion.”
  – “Acute” indexes correctly
  – ICD-10 code:
    • D62: Acute post hemorrhagic anemia
ABLAC: Conventional Thinking vs. ICD-10 Indexing

• Did you think you must always have “acute” documented in order to code acute blood loss anemia?

• ICD-10 index:
  – Anemia
    • Postoperative (postprocedural)
    • Due to (acute) blood loss: D62

Since acute is in parenthesis, it is a non-essential modifier.

The documentation only needs to specify “postoperative blood loss anemia” in order to assign code D62.

Caution: This seems to not be widely known, and you could run into audit problems or issues with coding auditors.

The indexing above is correct; however, it may not always work the way you expect due to the industrywide expectation that the word “acute” always be listed in order to assign D63.
“Classic” Coding Problem

- “Patient with severe PVD and long history of peripheral edema and blood pooling in lower extremities” (Patient clearly has a VENOUS disease)
  - ICD-10 code:
    - I73.9: PVD unspecified
      - Intermittent claudication
      - Peripheral angiopathy NOS
      - Spasm of artery

- “Patient with severe venous insufficiency and long history of peripheral edema and blood pooling in lower extremities”
  - ICD-10 code:
    - I87.2: Venous insufficiency (chronic) (peripheral)
“Classic” Coding Problem

- “Patient in acute respiratory compromise due to flash pulmonary edema requiring intensive diuresis”
  - ICD-10 code:
    - J81.1 Chronic pulmonary edema
    - Indexed by coder as: Pulmonary edema NOS

- “Patient in acute respiratory compromise due to acute pulmonary edema requiring intensive diuresis”
  - ICD-10 code:
    - J81.0 Acute pulmonary edema
“Classic” Coding Problem

• “Patient with acute onset cor pulmonale status post ARDS”
  – ICD-10 code:
    • I27.81: Cor pulmonale (chronic)

• There is no fix—there is no way to report this condition in ICD-10 as acute cor pulmonale
• Write to CMS and the Coordination and Maintenance committee
How to Report Acute Cor Pulmonale Due to Non-Embolic Causes?

• “Patient with acute-onset cor pulmonale status post ARDS”
  As per the advice in *Coding Clinic*, Fourth Quarter 2014 pp. 21–22:
  I27.81: Cor pulmonale (chronic)
• No code to capture “acute” cor pulmonale, unless it is due to an embolism.
• ARDS involves injury to the pulmonary circulation.
• Studies have reported as high as 22% prevalence of acute cor pulmonale in moderate to severe ARDS. It is important to detect acute cor pulmonale in these patients early to trigger specific therapeutic strategies to reduce RV afterload.

(Dessap et al., 2016)
Cor Pulmonale (cont.)

- Clinical guidance must remind physicians that new onset right-sided heart failure **NOT** due to left-sided heart failure is likely cor pulmonale.
- Not easy to report accurately in ICD-10 and there is little guidance on the matter.
- No severity weight attached to either right-sided heart failure codes (even when specified as acute) or chronic cor pulmonale.
Discrimination Against Right-Sided Heart Failure!

- Acute RV failure is seen with increasing frequency in ICU and, when severe, can contribute to hemodynamic instability and insufficient oxygen delivery.
- Uses significant amount of resources, but none of these codes are CCs/MCCs:
  - I50.810 Right heart failure, unspecified
  - I50.811 Acute right heart failure
  - I50.812 Chronic right heart failure
  - I50.813 Acute on chronic right heart failure
  - I50.814 Right heart failure due to left heart failure

(Ventetuolo & Klinger, 2014)
Changing Guidance 2019 Final Rule

- **2018 Official Coding Guidelines:** CKD should not be coded as hypertensive if the physician has specifically documented a different cause.

- **2019:** CKD should not be coded as hypertensive if the provider indicates the **CKD is not related to the hypertension.**
  
  - Section 1.8.9.a.1 Hypertensive Chronic Kidney Disease

- Assign codes from category I12, Hypertensive chronic kidney disease, when both hypertension and a condition classifiable to category N18, Chronic kidney disease (CKD), are present.

- As usual the choice of words can lead to much confusion. Does this new guideline mean that the provider needs to specifically state the heart failure is NOT related to the hypertension now? It appears so.

- We have submitted a *Coding Clinic* question to clarify this specific issue, and we encourage others to do the same.
Changing Guidance 2019 Final Rule

This pattern REPEATS throughout guidelines where assumed relationships are stated via “with” or “in”—for example:

- **2018:** The same heart conditions (I50.-, I51.4–I51.9) with hypertension are coded separately if the provider has specifically **documented a different cause.**

- **2019:** The same heart conditions (I50.-, I51.4–I51.7, I51.89, I51.9) with hypertension are coded separately if the provider **has documented they are unrelated** to the hypertension.
  
  — Section 1.8.9.a.1 Hypertension with Heart Disease

- Hypertension with heart disease
- Hypertension with heart conditions classified to I50.- or I51.4–I51.7, I51.89, I51.9 are assigned to a code from category I11, Hypertensive heart disease.
“if the provider has documented they are unrelated”
vs
“if the provider has specifically documented a different cause”

- “Patient has long history of aortic stenosis resulting in heart failure with new onset hypertension and history of CKD”

- 2018 DRG: HF acute systolic, CKD, HTN, AS:
  - I50.21 N18.3 I10 I35.0 = DRG 293 GMLOS 2.4, RW 0.6656

- 2019 DRG: Combo code: Hypertensive heart/kidney disease, acute systolic HF, CKD 3, AS:
  - I13.0 I50.21 N18.3 I35.0 = DRG 291 GMLOS 4.1, RW 1.3454

Potential coding issue: “But the doctor didn’t SPECIFICALLY say it was ‘unrelated’!”
DRG 291 Discrepancy Between CMS v36 Grouper & CMS v35 Grouper

• The issue involves the following acute HF codes, which are normally MCC conditions:
  – I50.21 Acute systolic heart failure
  – I50.31 Acute diastolic heart failure
  – I50.41 Acute combined systolic and diastolic heart failure

• FY 2018 CMS v35 grouper:
  – None of the 3 codes qualified as an MCC when the PDX is I11.0 (Hypertensive heart disease with heart failure)

• FY 2019 CMS v36 grouper:
  – I50.21 and I50.31 now qualify as MCCs when the PDX is I11.0
  – I50.41 is still excluded
DRG 291 Discrepancy (cont.)

• Why the sudden change in the CC/MCC exclusion tables, with no mention about it in the final rule?

• Why is I50.41 (acute combined systolic and diastolic heart failure) excluded?
  – Either exclude all 3 or allow all 3

• Why does the change not extend to any of the “acute-on-chronic HF” codes?
  – Is it because in an already established presence of a chronic heart failure, the diagnosis of an exacerbation does not lead to a significant rise in resource consumption compared to a newly diagnosed acute heart failure?
When Coding Doesn’t Keep Up With Healthcare

- Patient presents with acute non-ischemic myocardial injury
  - Possible causes:
    - Heart failure cardiomyopathy
    - Myocarditis or Takotsubo
    - Defib shocks
    - Sepsis
    - CKD
    - Stroke
    - PE
    - Chemo
    - Critical Illness
    - Connective tissue dz
    - Strenuous physical activity

- ICD-10 index:
- Injury
  - Myocardial: (See injury: Heart)
  - Cardiac: No entry
  - Heart: S26.90 (This is a trauma code)
- First Quarter 1992, pp. 9–10
- The physician has documented acute myocardial injury. There is no evidence of an MI based on enzymes and ECG.
- Coding Clinic advice: Assign “other forms of acute and subacute forms of ischemic heart disease”
- But we just established THERE IS NO ISCHEMIA!
- Since there is no traumatic injury and no ischemic events, we cannot recommend you actually follow EITHER of these two pieces of advice.
When Coding Doesn’t Keep Up With Healthcare

- The cardiac injury COULD be integral to many conditions that stipulate structural cardiac damage (such as Takotsubo, AMI, cor pulmonale, cardiomyopathies, cardiac injuries, postoperative states and acute myocarditis) and may not meet the UHDDS definition of a secondary diagnosis.
- When cardiac injury IS separately reportable and independently clinically significant, we have no current code in ICD-10 for it.
- It has been suggested that functional disorders causing cardiac injury (such as heart failure, pericarditis, sepsis, shock ESRD, etc.) be reported to ICD-10 code I52, Other heart disorders in diseases classified elsewhere, when they do not qualify as a type 2 MI.
- We also cannot advise you follow ICD-10 indexing to include hypertensive heart disease as a combination code for cardiac injury unless it is specifically stated and obviously not integral to an already named condition.
- Watch Coding Clinic closely for updates on this issue.
ICD-10 Indexing and Rules vs. Actual Index

• 2019 Official Coding Guidelines p. 25
  – “If the reason for admission is both sepsis or severe sepsis and a localized infection such as pneumonia or cellulitis, a code(s) for the underlying systemic infection should be assigned first followed by the code for the secondary diagnosis, assigned as the principal diagnosis”
  – Shigella is the LOCALIZED infection, not the SYSTEMIC infection

• ICD-10 index:

• Sepsis
  – Shigella—See also dysentery, bacillary:
    • A03.9
    • A03.9: Shigellosis unspecified
      = DRG 373 Major GI disorders without MCC

• What to do? Follow the guideline or follow the index:
  – One possibility:
  – PDX: A41.89: Other specified sepsis
  – SDX: A03.9 Shigellosis unspecified
    = DRG 872 Sepsis without an MCC

• Is this a case of “a basic rule of coding is that if the indexed condition does not appear to identify the condition correctly, further research is required?”
Conflicting Advice Within Coding Clinic

• We try to give advice that will result in reported data to the BEST clinical truth and the best conveyance of the provider’s documentation and intent, but this is what we are up against:

• Fourth Quarter 2018, p. 92:
  – “Advising coders to disregard Coding Clinic because of differences in understanding or personal interpretation may be construed as an ethical issue.”

• Fourth Quarter 2018, p. 90:
  – “For example, when the index is confusing, and leads to an inappropriate code, a basic rule is that further research is required if the title of the code suggested by the index clearly does not identify the condition correctly.”

• Well, which is it? Do we work with doctors and coders to try and make sure the condition is identified correctly, or be accused of ethical violations for discouraging a straight interpretation of all Coding Clinic advice and indexing? Contrary to what is suggested, this is an either/or proposition.
What to Do?

• **Coding Clinic**, Fourth Quarter 2018, p. 91:
  • “If coding professionals feel that published advice is in conflict with coding guidelines or the ICD-10-CM/PCS classification, please submit a specific case example to the AHA Central Office, with potential for submission to the Coding Clinic Editorial Advisory Board for review.”

• At the bottom of every **Coding Clinic** letter it says:
  – “Any reprint or distribution of all or part of this correspondence, without the express written consent of the American Hospital Association’s Central Office on ICD-10-CM and ICD-10-PCS, is strictly prohibited.”
  – i.e., the answer contained is neither official advice nor useful in sharing with others, dealing with auditors or for general education purposes.
Deciding Between Pieces of Conflicting Advice

• Coding Clinic, Fourth Quarter 2018, p. 87: In cases of Excludes1 notes: “We have not been able to locate official guidance as to which code should be assigned out of the two codes.”
  – Answer: “Assign only the code referenced in the Excludes1”

• J03 Acute tonsillitis
  – Excludes1:
    • Gangrenous pharyngitis (acute)
    • Infective pharyngitis (acute) NOS
    • Pharyngitis (acute) NOS
    • Sore throat (acute) NOS
    • Suppurative pharyngitis (acute)
    • Ulcerative pharyngitis (acute)

• What to do? Ignore the Coding Clinic and defer to the Official Coding Guidelines?

• Official Coding Guidelines FY 2019 p. 14: “Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider.”
Encephalopathy Due to UTI Is Most Often Metabolic in Nature

• The inflammatory mechanism that causes AMS in a patient with a UTI most closely fits the clinical definition of a metabolic encephalopathy (unless there are other factors involved).

• “How should encephalopathy due to UTI be coded?”
  – “Assign codes G93.49, Other encephalopathy, and N39.0, Urinary tract infection, site not specified.”
    • Coding Clinic, Second Quarter 2018 p. 22

• Basic coding guidelines stipulate that ICD-10 codes should always be assigned to the highest possible specificity where applicable. In this instance, a query for the precise type of encephalopathy should be placed.
Inconsistent Guidance About Encephalopathy

• **Postictal phase**

In general, nonsignificant clinical findings that are not separately managed, are integral to an already established diagnosis, or are routinely associated with the outcomes of a surgery or diagnosis are not reported.

Self-limiting non-treated conditions may at times also not be reportable under the UHDDS definitions requiring clinical evaluation, treatment, additional diagnostic procedures, increased nursing care, or extended length of stay.

• **Coding Clinic, Fourth Quarter 2013 p. 89:**
  - A patient in a postictal stay is intrinsic to the condition up to 48 hours (paraphrased)
    • 48 hours is the absolute outer limit of recovery from a postictal state
    • Additional referrals, testing, treatment and nursing monitoring will most often be required if focal reactions and some return of consciousness has not begun to occur within a 30 to 90 minute period
    • Non-recovery from a postictal state may indeed be both clinically significant and reportable in less than 48 hours under the UHDDS definition
    • The clinical significance should be left up to the physician, not an arbitrary use of the clock
Inconsistent Guidance About Encephalopathy (cont.)

• **Encephalopathy in hypoglycemia**
  
  • *Coding Clinic*, Third Quarter 2016, p. 43:
    - “Encephalopathy” in a patient who is transiently hypoglycemic
      • “Codes E11.649, Type 2 diabetes mellitus with hypoglycemia without coma, and G93.41, Metabolic encephalopathy are the correct code assignments for metabolic encephalopathy due to diabetic hypoglycemia.”
    
  • A transient AMS that is corrected via nursing intervention of pushing foods or administering a quick glucose-based solution with no real need for additional monitoring, evaluation, increased length of stay, diagnostic testing procedures, or additional treatment beyond a simple diabetic protocol may indeed represent potential for abuse as CDI seeks to upcode this to an MCC-level diagnosis.
  
  • There may be clinically significant cases of diabetic hypoglycemia reportable as encephalopathy, but this blanket statement by the AHA sets us all up for yet more audits, potential qui tam lawsuits, etc.
Inconsistent Guidance About Encephalopathy (cont.)

• A clinical threshold of higher severity is recommended in cases where an exception should be made to report G93.41 as an MCC, and it should include some commonsense criteria. Some examples (not comprehensive):
  – Extended AMS/refractory to therapy
  – Move to a higher-level unit
  – Endocrine consult
  – Neurology referral
  – Frequent neuro checks or EEG
  – Need for repeated doses of glucose based medication for repeated episodes of AMS with low blood sugar

• Again, the decision of clinical significance should be a clinical one made by the MD, not an edict handed down by Coding Clinic.
Inconsistent Guidance About TIAs

- Second Quarter 2018, p. 9

- Question: A 73-year-old female presents due to intermittent episodes of balance and vision changes with right hemiparesis. She is diagnosed with transient ischemic attack (TIA) due to bilateral carotid artery stenosis, with left side symptomatic stenosis. There is an Excludes1 note under category I65-, Occlusion and stenosis of precerebral arteries, not resulting in cerebral infarction, that prohibits the reporting of a code from this category with the TIA code.

- Answer: Assign only code I65.23, Occlusion and stenosis of bilateral carotid arteries, for this patient. The Excludes1 note under category I65 prohibits assigning codes in category G45 (Nonspecific precerebral artery insufficiency), because the cause of the insufficiency is clearly specified as carotid artery stenosis.
Inconsistent Guidance About TIAs

- Is a TIA a routine finding in carotid stenosis?
  - No.

- Could I look at a list of ICD-10 codes and reasonably assume the patient had a TIA from a carotid stenosis code without opening up the record?
  - No.

- Might I need both the carotid stenosis and the TIA reported in order to fully understand the patient’s status in the interest of accuracy, completeness, and clinical truth?
  - Yes.

- Are the risk factors and treatment protocols the same for a patient with carotid stenosis with current active TIA vs. a patient with asymptomatic stenosis?
  - No.
Inconsistent Guidance About TIA's (cont.)

• Is there ANY clinical basis for assuming a patient with asymptomatic carotid stenosis is the same as a patient with stenosis who is actively symptomatic?
  – No—especially not in the acute inpatient hospital setting.

• Would the approval process for an urgent intervention for a stenotic, actively symptomatic patient be the same as for the relatively elective interventions for a non-symptomatic patient?
  – No.

• Might we have reason to question Coding Clinic on this?
  – Yes. Write to Coding Clinic and request a correction.
Beware: The presence of localized or generalized peritonitis is NOT generating major severity.

K35 Acute appendicitis

K35.2 Acute appendicitis with generalized peritonitis
Appendicitis (acute) with generalized (diffuse) peritonitis following rupture or perforation of appendix

Without Abscess

K35.20 Acute appendicitis with generalized peritonitis, without abscess
(Acute) appendicitis with generalized peritonitis NOS

MCC

K35.21 Acute appendicitis with generalized peritonitis, with abscess

The presence of an abscess provides the MCC, NOT the peritonitis
Beware: The presence of localized or generalized peritonitis is NOT generating major severity.

K35.3 Acute appendicitis with localized peritonitis

- **K35.30** Acute appendicitis with localized peritonitis, without perforation or gangrene
  - Acute appendicitis with localized peritonitis NOS

- **K35.31** Acute appendicitis with localized peritonitis and gangrene, without perforation

- **MCC** K35.32 Acute appendicitis with perforation and localized peritonitis, without abscess
  - (Acute) appendicitis with perforation NOS
  - Perforated appendix NOS
  - Ruptured appendix (with localized peritonitis) NOS

- **MCC** K35.33 Acute appendicitis with perforation and localized peritonitis, with abscess
  - (Acute) appendicitis with (peritoneal) abscess NOS
  - Ruptured appendix with localized peritonitis and abscess

The presence of a perforation provides an MCC, with or without abscess
Generalized Peritonitis > Localized Peritonitis

- Appendicitis leading to generalized peritonitis won’t be an MCC, whereas acute appendicitis with abscess with localized peritonitis will be an MCC
- Generalized peritonitis frequently accompanied by perforation
  - Defined as presence of contamination in two or more quadrants
- Localized peritonitis is confined to a demarcated region of the peritoneal cavity surrounding a focal lesion
  - Has better prognosis
  - Usually less life-threatening than the generalized type
  - May progress and develop into generalized peritonitis
  - The abdominal tenderness is diffuse and the inflammation is widespread

(Schein & Rogers, 2005)
(Hernandez et al.)
2019 AHIMA/ACDIS Query Practice Brief

- The quality of clinical indicators—how well they relate to the condition being clarified—is more important than the quantity of clinical indicators.
- Clinical indicators can be identified from sources within the entirety of the patient’s health record, including emergency services, diagnostic findings, and provider impressions as well as relevant prior visits, if the documentation is clinically pertinent to the present encounter.

(AHIMA, 2019)
Queries using information from prior encounters may be utilized when relevant in the following situations (and others):

- Establish a cause-and-effect relationship
- Determine the etiology when only signs, symptoms, or treatment are documented
- Verify POA indicator status
- Clarify a prior history of a disease that is no longer present (e.g., history of a neoplasm)

(AHIMA, 2019)
“A query cannot be based solely on the information from a prior encounter; there must be relevant information within the current encounter to substantiate the query.”

In other words, what did you SEE in this record that caused you the NEED to go back and look at RELEVANT and RELATED data and documentation? If the answer is “there’s nothing in the current record that WOULD make me go back,” you could have an issue.

– If you can point to the issue in the current chart, you should be good to go.
– Examples: Heart failure, mental status questions, renal history, nutritional issues, medication records that indicated treatment for an unnamed diagnosis, suspicious laboratory findings presenting the need to ascertain the difference between acute vs. chronic changes, surgical history indicating diagnoses are resolved or devices may be present, etc.

(AHIMA, 2019)
2016 AHIMA Standards of Ethical Coding

“Query and/or consult as needed with the provider for clarification and additional documentation prior to final code assignment in accordance with acceptable healthcare industrial practices.

Coding professionals shall not:

4.5: Utilize health record documentation from or in other encounters to generate a provider query.”

The coder may get hung up on this “discrepancy,” but we don’t recommend spending too much time worrying about it. The discrepancy is just an artifact of the update cycles, and the Standards of Ethical Coding are said to be scheduled for an update. In the interim and at the time of this slide being produced, a joint AHIMA/ACDIS FAQ is slated to address this issue.

(AHIMA, 2016)
How to Fix the “Permanent AIDS (B20)” Conundrum?

• For patients with any known prior diagnosis of AIDS, make sure AIDS is documented during every visit!
• New AHIMA/ACDIS query practice brief (2019)
  – Allows a constructing query to clinically validate a diagnosis present in a prior health record
  – Prior encounter information should be referenced in queries for clinical clarification and/or validation

(AHIMA, 2019)
Other Issues ... Code Set Is Far From Perfect!

- Need to build codes that capture cancer staging
  - Has far more prognostic value than any other single piece of information about cancers!
- Lack of cirrhosis specificity
  - At the very least, there should be compensated and decompensated (CC and MCC, respectively)
  - Ideally, need to have severity codes for cirrhosis be based on Child-Pugh score (A, B, or C)
- Update reporting of AIDS
  - “Once AIDS, always AIDS” is no longer clinically valid
  - Reporting of HIV and AIDS should not be a binary choice, and should be correlated with patient’s immune status based on CD4 count and HIV RNA levels
  - Need to reflect patients achieving immune reconstitution due to antiretroviral therapy
Clinical Validation

You have the “buzzwords” ... so you are done, right? Wrong.

2019 AHIMA clinical validation update:
Issuing a clinical validation query is simply requesting that the practitioner confirm the presence of the condition and provide additional rationale for common scenarios such as:

• A diagnosis was documented, but the patient has an atypical presentation
• A diagnosis appears to lack the clinical indicators needed to meet organizational or payer criteria
• A documented diagnosis appears to be no longer valid, but the documentation does not show the condition as ruled out/eliminated/resolved

Coding Clinic, Fourth Quarter 2017, p. 110:
“If after querying, the attending physician affirms that a patient has a condition despite certain clinical parameters not being met, the facility should request the physician document the clinical rationale and be prepared to defend the condition if challenged in an audit. The facility should assign the appropriate code(s) for the conditions documented.”
Clinical Validation: RNs and Clinicians Only?

• Many organizations support both CDI and coding professionals as authors of clinical validation queries. Adequately trained query professionals should not be prevented from writing clinical validation clarification queries based on their credentials and/or background (e.g., HIM coding background versus clinical background).
  

• “When a query professional writes a clinical validation query, they are not performing clinical validation. Rather, they are highlighting a potential gap between a documented diagnosis and the clinical evidence in the health record.”

• AHIMA has reversed/revised its previous position that such query writing is “beyond the skills of a certified coder” when that coder is a hospital employee placing a clinical validation query.
  
  – Therefore, if you have coders on your CDI team, they should be addressing these types of queries the same as all staff members.

(AHIMA, 2019)
References


Thank you. Questions?

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