AAPC

HEALTHCON

DRG Pitfalls: What to look for in Documentation to Code Comorbid Conditions

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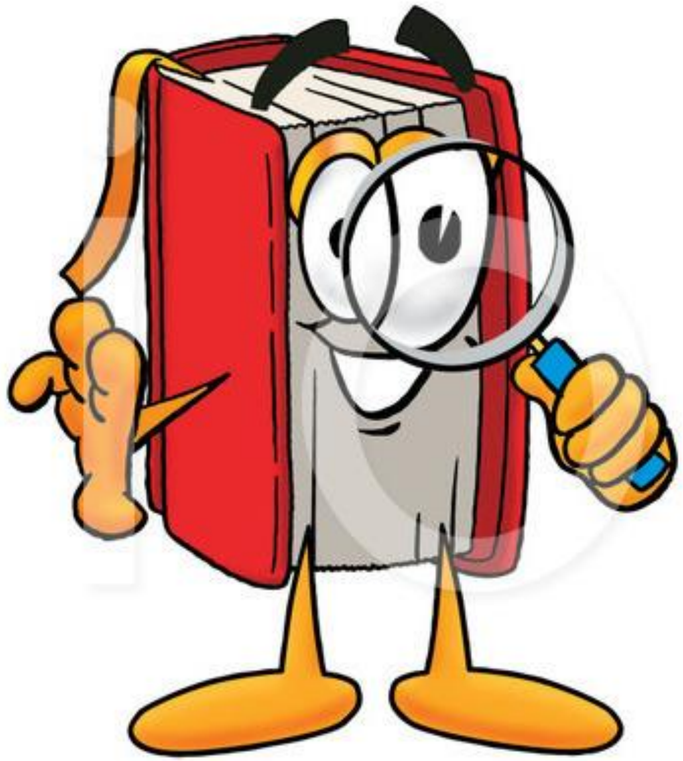
Agenda

- Acronyms & Definitions
- MCD & MS-DRG Hierarchies
- MCC/CC Documentation



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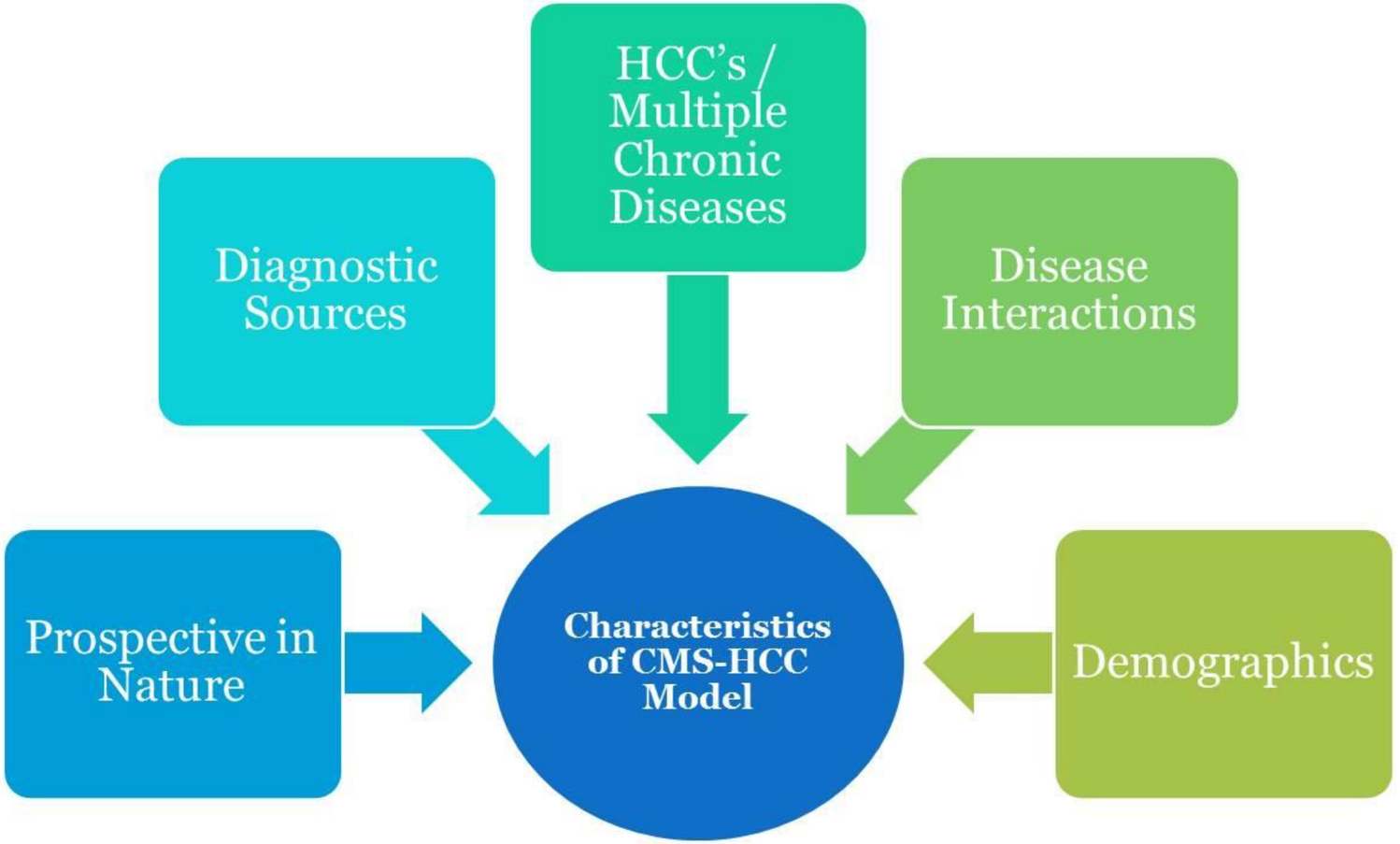
Acronyms & Definitions

- MCC – Major Complications & co-morbidities:
  - highest level of severity
- CC – Complications & co-morbidities:
  - moderate level of severity
- Non-CCs: lowest level of severity
- MDC: major diagnostic categories
  - The diagnosis that defines each MDC fall under the umbrella of a single organ system or etiology and are usually grouped by medical specialty
- Pre-MDC: The grouper's logic hierarchy for these procedures is higher than that of the principal diagnosis typically used to determine the MS-DRG
  - Intense resource procedures such as Tracheostomies or transplants
  - HCC – Hierarchal Condition Codes
    - Decides the reimbursement benefits for a Medicare Advantage Plan that uses ICD diagnostic codes as the primary indicators of the member's health status.


HCC's / Multiple Chronic Diseases
Diagnostic Sources
Disease Interactions
Prospective in Nature
Characteristics of CMS-HCC Model
Demographics

Hierarchal Condition Codes

- Hierarchy logic is imposed on certain disease groups, which is why the model is known as the Hierarchical Condition Category
- The HCC model is cumulative, meaning that a patient can have more than one HCC category assigned to him or her and each HCC is factored into the member's risk profile, depending on the number of current chronic disease processes.
- Disease groups are based on clinically related diagnoses that have similar Medicare cost implications
- Each disease group relates to a specific ICD-10-CM medical condition (e.g., diabetes and congestive heart failure)
- Documentation must include "linking statements" for all identified disease manifestations (e.g., "diabetes with peripheral vascular disease manifestations") to accurately report the chronic disease process that will be linked to the correlating HCC.

HCC Impact

- Patient care:
  - Accurately documenting chronic conditions that are being managed during an inpatient stay will enhance the quality of care they receive
- Physicians:
  - Will help them meet their quality measures that MACRA and MIPS will be requiring as they switch from quantity to quality (or value based.)
- Hospitals:
  - Will reap the rewards from above also possibly improve relationships with payers for making sure these diagnoses are being documented and coded correctly.
- Quality:
    - Quality reporting agencies will be happy and appeased – Documentation improves=quality improves
- “As with everything related to medical record documentation, the better it is, the more quality of care is given, the coding and reimbursement cycles are more efficient due to less denials and in your case, better chances for authorizations for increased or continued LOS”


Surgical Procedures
Comorbidities
Primary Diagnosis
DRG
Sex

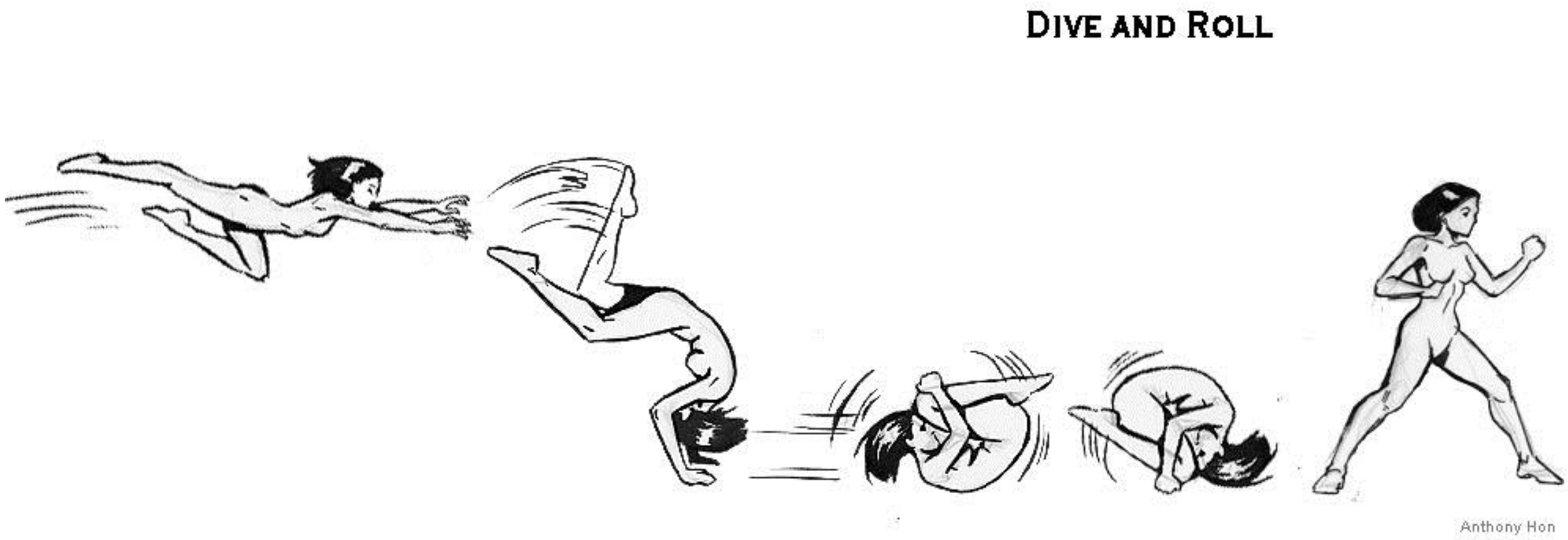
MDC & MS-DRG Hierarchies

1. Principal diagnosis is linked to an anatomical system (MDC)
2. Any surgical procedure status
3. Any MCC/CCs, as well as sex, discharge status and birth weight of neonates.

MCC if Discharged Alive

- I49.01, ventricular fibrillation
- I46.2, cardiac arrest due to underlying cardiac condition
- I46.8, cardiac arrest due to other underlying condition
- I46.9, cardiac arrest, cause unknown
- R57.0, cardiogenic shock
- R57.1, hypovolemic shock
- R57.8, other shock
- R09.2, respiratory arrest

MCC/CC Documentation



MCC/CC Documentation

- Anemia due to blood loss, acute (CC)
- Atrial Flutter (specific forms) (CC) (HCC)
- Atelectasis (CC)
- Malnutrition (certain forms) (MCC/CC) (HCC)
  - Cachexia (CC) (HCC)
  - Nutritional Marasmus (MCC) (HCC)
- Encephalopathy(CC)
- Renal failure acute/chronic Stage IV/V, ESRD (MCC/CC)(HCC)

Anemia

- D62, anemia due to blood loss, acute:
  - The result of rapid, sudden loss of blood following trauma, a hemorrhagic condition, hemophilia, acute leukemia or loss during surgery. Postoperative anemia due to blood loss must be evidenced by clinically significant lab values that are indicative of the diagnosis.
    - “acute” is not required
    - Must describe “[due to]blood loss”
    - This is not a complication code, it is simply a condition which is occurring after the surgery or trauma.
  - No treatment is required in order to report this code.
  - Peruse preoperative and postoperative labs for clinical indicators.

Atelectasis

- J98.11, Atelectasis: (CC)
  - Incomplete expansion of a lung or a portion of a lung; it may be a primary (congenital), secondary, or otherwise acquired condition. Some signs and symptom may include:
    - decreased breath sounds
    - dull chest percussions
    - sudden dyspnea
    - Cyanosis
    - Hypotension

Atelectasis

- Clinical findings
  - Cough
  - SOB
  - Fever
  - Dyspnea
  - Chest pain
- Diagnostic
  - Chest x-ray
  - Spirometry
  - Bronchoscopy
- Treatments
  - Nebulizer
  - Thoracentesis
  - Antibiotics
  - Diuretics

Pleural Effusion

- J90, Pleural Effusion (CC)
  - J91.8, Pleura Effusion in other conditions classified elsewhere (CC)
  - J91.1, Malignant Pleural Effusion (CC)
  - A build up of fluid in the space around the lung (Pleura)
    - Transudative pleural effusion is caused by fluid leaking into the pleural space. This is from increased pressure in the blood vessels or a low blood protein count.
      - Congestive heart failure is the most common cause.
    - Exudative effusion is caused by blocked blood vessels or lymph vessels, inflammation, lung injury, and tumors and or malignancies.

Pleural Effusion

- Clinical findings
  - Cough
  - SOB
  - Fever
  - Dyspnea
  - Chest pain
- Diagnostic
  - Chest x-ray
  - Chest CT/US
  - Thoracentesis
- Treatments
  - Thoracentesis
  - Antibiotics
  - Diuretics
  - Preventative measures to stop fluid build up

Pleural Effusion

- Coding Clinic 2Q 2015 pg 15-16
  - Code J91.8, Pleural effusion in other conditions classified elsewhere, is assigned as a secondary code only if the condition is specifically evaluated or treated.
  - Pleural effusion is commonly seen with congestive heart failure with or without pulmonary edema.
  - Ordinarily the pleural effusion is minimal and is not specifically addressed other than by more aggressive treatment of the underlying congestive heart failure.
    - In this situation it should not be coded.
  - However, it is acceptable to report pleural effusion (J91.8) as an additional diagnosis if the condition requires either therapeutic intervention or diagnostic testing

Malnutrition

- Malnutrition – (HCC)
  - E40 Kwashiorkor (MCC)
    - Severe malnutrition with nutritional edema with dyspigmentation of skin and hair
    - Excludes1: marasmic kwashiorkor (E42)
  - E41 Nutritional marasmus (MCC)
    - Severe malnutrition with marasmus
    - Excludes1: marasmic kwashiorkor (E42)
  - E42 Marasmic kwashiorkor (MCC)
    - Intermediate form severe protein-calorie malnutrition
    - Severe protein-calorie malnutrition with signs of both kwashiorkor and marasmus
  - E43 Unspecified severe protein-calorie malnutrition (CC)
    - Starvation edema
  - E44 Protein-calorie malnutrition of moderate and mild degree
    - E44.0 Moderate protein-calorie malnutrition (CC)
    - E44.1 Mild protein-calorie malnutrition (CC)
  - E45 Retarded development following protein-calorie malnutrition (CC)
    - Nutritional short stature
    - Nutritional stunting
    - Physical retardation due to malnutrition
  - E46 Unspecified protein-calorie malnutrition (CC)
    - Malnutrition NOS
    - Protein-calorie imbalance NOS
    - Excludes1: nutritional deficiency NOS (E63.9)

Malnutrition

- – (HCC)

A term used to refer to any condition in which the body does not receive enough nutrients for proper function.
May range from mild to severe and life-threatening. It can be a result of starvation, in which a person has an inadequate intake of calories, or it may be related to a deficiency of one particular nutrient (for example, vitamin C deficiency). Malnutrition can also occur because a person can not properly digest or absorb nutrients from the food they consume, as may occur with certain medical conditions. Malnutrition remains a significant global problem, especially in developing countries.

Medicinenet.com

Malnutrition

Kwashiorkor (MCC)

Payments for Patients Diagnosed with Kwashiorkor

Kwashiorkor is a form of severe protein malnutrition that generally affects children living in tropical and subtropical parts of the world during periods of famine or insufficient food supply. It is typically not found in the United States. A diagnosis of kwashiorkor on a claim substantially increases the hospitals' reimbursement from Medicare. Prior OIG reviews have identified inappropriate payments to hospitals for claims with a kwashiorkor diagnosis. We will review Medicare payments made to hospitals for claims that include a diagnosis of kwashiorkor to determine whether the diagnosis is adequately supported by documentation in the medical record. We will roll up the results of our audits of Medicare hospital payments for kwashiorkor to provide CMS with cumulative results and make recommendations for any appropriate changes to the program.

OAS: W-00-15-35715; various reviews • Expected Issue Date: FY 2017

HHS / OIG Work Plan | Fiscal Year 2017

Malnutrition

- E41, Nutritional marasmus(MCC)
  - A severe form of malnutrition that consists of the chronic wasting away of fat, muscle, and other tissues in the body. Malnutrition occurs when your body does not get enough protein and calories. This lack of nutrition can range from a shortage of certain vitamins to complete starvation.
    - Emaciated codes to this in ICD-10-CM
      - Index: Emaciated (due to malnutrition)
    - More common in the US
    - Usually in very young children

Malnutrition

- R64, Cachexia (CC)(HCC)
  - A profound and marked state of constitutional disorder; general ill health and malnutrition. (wasting syndrome)
    - Code first underlying condition, if known
    - Commonly found in RA, AIDS, severe infections and certain types of cancer.
    - Coding Clinic 1Q 2013
    - If only emaciated is documented, then it should code to cachexia

Malnutrition

- The chart should have the following documented:
  - Insufficient energy (calorie) intake
  - Weight loss
  - Loss of muscle mass
  - Loss of subcutaneous fat
  - Localized/generalized fluid accumulation that may mask weight loss (edema).
  - Diminished functional status (measured by hand grip strength).
  - For severe malnutrition there must be documentation of the more severe symptoms as well as the indicators above.

Malnutrition

Measurement	Normal	Mild Malnutrition	Moderate Malnutrition	Severe Malnutrition
Percent of Normal Body weight	90-100%	85-95%	75-85%	<75%
BMI	19-24	18-18.9	16-17.9	<16
Serum albumin	3.5-5.0	3.1-3.4	2.4-3.0	<2.4
Serum Transferrin	220-400	201-219	150-200	<800
Total lymphocyte count/mm3	2000-3500	1501-1999	800-1500	<800

Encephalopathy

- G92 Toxic encephalopathy (MCC)
  - Toxic encephalitis
  - Toxic metabolic encephalopathy
  - Code first (T51-T65) to identify toxic agent
- G93.1 Anoxic brain damage, not elsewhere classified (CC)
  - Excludes1: cerebral anoxia due to anesthesia during labor and delivery (O74.3)
  - cerebral anoxia due to anesthesia during the puerperium (O89.2)
  - neonatal anoxia (P84)

Encephalopathy

- G93.4 Other and unspecified encephalopathy Excludes1: alcoholic encephalopathy (G31.2)
    - encephalopathy in diseases classified elsewhere (G94)
    - hypertensive encephalopathy (I67.4)
    - toxic (metabolic) encephalopathy (G92)
  - G93.40 Encephalopathy, unspecified (MCC)
  - G93.41 Metabolic encephalopathy (MCC)
    - Septic encephalopathy
- G93.49 Other encephalopathy (MCC)
    - Encephalopathy NEC

Encephalopathy

- Encephalopathy:
  - General term that means brain disease, damage, or malfunction.
  - Major symptom of encephalopathy is an altered mental state
- The term is vague – educate practitioners to clarify the reason:
  - Causal condition
  - Substance

Encephalopathy

- Toxic encephalopathy
  - Brain tissue degeneration due to a toxic substance
  - Usually refers to the effects of drugs, toxins or poisons.
  - Can be used clinically to refer to encephalopathy caused by conditions such as fever or sepsis
- Anoxic encephalopathy
  - Lack of Oxygen
    - Cardiopulmonary arrest
    - Prolonged seizures w/inadequate breathing
    - Prolonged asthma attacks
    - Exacerbation of COPD

Encephalopathy

- Metabolic encephalopathy
  - Potentially reversible and is due to metabolic causes;
    - Infections or fever
    - Dehydration or electrolyte imbalance
    - acidosis, hypoxia and/or organ failure
  - ** septic encephalopathy is a clinical term that expresses brain dysfunction as a manifestation of severe sepsis.
  - ** diabetic patient's with hypoglycemic encephalopathy would be coded with the appropriate DM code and G93.41

Encephalopathy

- Other encephalopathy:
  - Should be coded when it is due to a condition which does not fit one of the defined categories.
- Encephalopathy, unspecified
  - Should rarely be used
  - Query for clarification

Encephalopathy

- A patient with DM2 is admitted with altered mental status, after study the patient is found to have hypoglycemic encephalopathy.

- What do you code?

Encephalopathy

- E11.649, Type 2 diabetes mellitus with hypoglycemia, without coma
- G93.41, Metabolic encephalopathy
- DRG 637 Diabetes w/ MCC

Encephalopathy

- Look for:
  - Altered mental status
  - Dementia
  - Seizures
  - Tremors
  - Muscle twitching
  - Poor coordination
- Diagnostic procedures:
  - CBC or glucose
  - Electrolyte levels or ammonia
  - Liver functions or creatinine
  - Drug screens or lead levels
- Imaging:
  - Head CT
  - Head MRI
  - Doppler study
  - EEG

Encephalopathy – what if?

- E16.2, Hypoglycemia unspecified
- DRG 641 Misc. Disorders of nutrition, metabolism, fluid/electrolytes w/o MCC

Encephalopathy – what if?

- E16.2, Hypoglycemia unspecified
- G93.41, Metabolic encephalopathy
- DRG 640 Misc. Disorders of nutrition, metabolism, fluid/electrolytes w/MCC

Encephalopathy due to Malnutrition

- Must have documentation of the connection between the encephalopathy and malnutrition
  - Should be in labs or clinical documentation
- Must show improvement of the encephalopathy secondary to nutritional support/treatment.

Chronic Kidney Disease

- N18.1 Chronic kidney disease, stage 1 (HCC)
- N18.2 Chronic kidney disease, stage 2 (mild) (HCC)
- N18.3 Chronic kidney disease, stage 3 (moderate) (HCC)
- N18.4 Chronic kidney disease, stage 4 (severe) (CC) (HCC)
- N18.5 Chronic kidney disease, stage 5 (CC) (HCC)
- Excludes1: chronic kidney disease, stage 5 requiring chronic dialysis (N18.6)
- N18.6 End stage renal disease (MCC) (HCC)
- N18.9 Chronic kidney disease, unspecified

Chronic Kidney Disease

- Chronic Renal Insufficiency is not the same as chronic renal failure, and shouldn't be used to represent renal failure (acute or chronic)
- Look for related conditions
- Dialysis status and frequency, if applicable
- If a patient has hypertension, heart disease and chronic kidney disease then a code from the 'Hypertensive Heart and Chronic Kidney Disease' section should be used, not individual codes for hypertension, heart disease and chronic kidney disease

Chronic Kidney Disease

- Over the last few decades, more than 35 different definitions have been used to define acute kidney injury (AKI)

- Many of those definitions were complex; however, the more commonly used were based on urine output (UO) and/or serum creatinine (SCr) criteria.

- Multiple definitions for AKI have obviously led to a great disparity in the reported incidence of AKI making it difficult or even impossible to compare the various published studies focusing on AKI

Chronic Kidney Disease

- KDIGO

CKD is defined as abnormalities of kidney structure or function, present for >3 months, with implications for health and CKD is classified based on cause, GFR category, and albuminuria category (CGA).

Prognosis of CKD by GFR and albuminuria category

Prognosis of CKD by GFR and Albuminuria Categories: KDIGO 2012

GFR categories (ml/min/ 1.73 m²) Description and range				Persistent albuminuria categories Description and range		
				A1 Normal to mildly increased	A2 Moderately increased	A3 Severely increased
				<30 mg/g <3 mg/mmol	30-300 mg/g 3-30 mg/mmol	>300 mg/g >30 mg/mmol
	G1	Normal or high	≥90			
	G2	Mildly decreased	60-89			
	G3a	Mildly to moderately decreased	45-59			
	G3b	Moderately to severely decreased	30-44			
	G4	Severely decreased	15-29			
	G5	Kidney failure	<15			

Green: low risk (if no other markers of kidney disease, no CKD); Yellow: moderately increased risk; Orange: high risk; Red, very high risk.

Chronic Kidney Disease

Stage	Description	GRF(mL/min/1.73m^2)
1	Kidney damage with normal or elevated GFR	$\geq$ 90
2	Kidney damage with mild or lower GFR	60-89
3	Moderate lower GFR	30-59
4	Severe lower GFR	15-29
5	Kidney Failure	>15

Chronic Kidney Disease

- Document the Stage of CKD
- Document Causality if Known (including linkage to the disease)
- Diabetic CKD + Stage
- Hypertensive CKD + Stage

Acute Kidney Failure

- Document underlying condition(s) contributing/causing acute renal failure if known or suspected
- Document if acute kidney injury (AKI) is due to traumatic injury or if due to a non-traumatic event
- Document if acute renal failure is due to:
  - Acute tubular necrosis (ATN)
  - Acute cortical necrosis
  - Acute medullary necrosis
  - Other (specify)
- Be specific with documentation
  - Acute renal insufficiency and acute kidney disease are not reported as acute renal failure
- Document any associated diagnoses/conditions

COPD

- J44.0 Chronic obstructive pulmonary disease with acute lower respiratory infection (CC) (HCC)
  - Use additional code to identify the infection
- J44.1 Chronic obstructive pulmonary disease with (acute) exacerbation (CC) (HCC)
  - Decompensated COPD
  - Decompensated COPD with (acute) exacerbation
  - Excludes2: chronic obstructive pulmonary disease [COPD] with acute bronchitis (J44.0)
- J44.9 Chronic obstructive pulmonary disease, unspecified (HCC)
  - Chronic obstructive airway disease NOS
  - Chronic obstructive lung disease NOS

COPD

- Chronic obstructive pulmonary disease with acute lower respiratory infection
  - An acute exacerbation of COPD is not the same thing as a superimposed infection,
    - exacerbation may be triggered by the infection
  - Coding Clinic 3Q2016, Pg15 &16
    - J44.0 must be sequenced first
    - J44.0 includes acute bronchitis and pneumonia –should code
      - Does not include influenza – should not code

COPD

- Chronic obstructive pulmonary disease with (acute) exacerbation (Decompensated COPD)
  - This is a decompensation of the disease
    - Wheezing
    - SOB
  - Treatment is trying to relieve symptoms and return to baseline
  - Coding Clinic 3Q2016 Pg 15-16
    - Can code J44.0 and J44.1, when both are present, along with the lower respiratory infection
    - Either J44.0 or J44.1 may be sequenced first.

COPD Exacerbation w/ Pneumonia

- Patient admitted with COPD and pneumonia. Placed on IV SoluMedrol as patient was not responding to bronchodilators. Patient also placed on oxygen. IV antibiotic was prescribed for the Staph pneumonia.

- What do you code?

COPD Exacerbation w/ Pneumonia

- J44.0, COPD with acute lower respiratory infection as PDX
- J15.29, Staph pneumonia (MCC)
- DRG 190, COPD with MCC

COPD Exacerbation w/ Pneumonia

- Patient admitted with COPD and Staph pneumonia. Placed on IV antibiotics for pneumonia. Continue with bronchodilators and inhaled steroids for COPD.

- What do you code?

COPD Exacerbation w/ Pneumonia

- J44.0, COPD with acute lower respiratory infection as PDX
- J15.29, Staph pneumonia (MCC)
- DRG 190, COPD with MCC

Pneumonia w/ COPD Exacerbation

- J15.29, Staph pneumonia (MCC)
- J44.0, COPD with acute lower respiratory infection
- DRG 194, Simple Pneumonia & pleurisy w CC
- We could not code this sequence, per ICD-10-CM and coding clinic guidance.
- The DRG should catch our attention

Questions

CEU Code

CEU: B853

References

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