Trending Issues in Inpatient Coding

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Trending Issues in Inpatient Coding

- The intent of this presentation is to discuss real inpatient cases that incurred MS-DRG changes on recent reviews based upon ICD-10 coding conventions.

- We will discuss recently released Coding Clinic advice from First Quarter 2017.

- We will discuss RIFLE and KDIGO criteria for acute renal failure, KDIGO classification system for acute renal failure and Sepsis-3 SOFA Clinical Criteria.

- As time allows at the end of the presentation, any questions/comments will be welcomed.
COPD Exacerbation with Pneumonia

• A 71-year-old female was admitted for evaluation and treatment of COPD exacerbation and pneumonia. Per H&P, she has had progressive cough and shortness of breath for the past 2 weeks. It started as a cough, low grade fever 2 weeks ago and was started on antibiotic cefuroxime 250 mg x 7 days. Assessment: COPD with acute pneumonia. Plan: COPD with acute exacerbation → IV levofloxacin, IV solumedrol 40 mg q 8 hours, ATC bronchodilators, low flow oxygen, mucolytic.

• Based upon this scenario, ICD-10 guidelines & Coding Clinic advice, what would you recommend as principal diagnosis?
COPD Exacerbation with Pneumonia

There is an instructional note in the ICD-10 tabular index under code J44.0 (COPD with acute lower respiratory infection) which states:

“Use an additional code to identify the infection”

This note raised many questions – mainly did this just have to be an established diagnosis of COPD? HIA queried AHA and received a response in December 2015 that clarified yes – code J44.0 would be sequenced first followed by the code for pneumonia. AHA went on to publish this advice in Coding Clinic 3Q, 2016.

Rather than being able to report either J18.9 (Pneumonia, unspecified organism) or J44.1 (COPD with acute exacerbation) as principal diagnosis, the options become either J44.1 (COPD with acute exacerbation) or J44.0 (COPD with acute lower respiratory infection). Both J44.1 and J44.0 group to the same MS-DRG. Code J18.9 would be reported as a secondary diagnosis as this is an acute lower respiratory infection as noted in the instructional note below.

MS-DRG wise – clients lose since they no longer report pneumonia as principal diagnosis which, in this case, would have reported to 193/1.4261. It now reports to 190/1.1578.
COPD Exacerbation with Pneumonia

Acute exacerbation of chronic obstructive pulmonary disease with pneumonia


Question: What are the diagnosis code assignments for an acute exacerbation of COPD with pneumonia? Is it appropriate to assign code J44.0, Chronic obstructive pulmonary disease with acute lower respiratory infection, and code J44.1, Chronic obstructive pulmonary disease with (acute) exacerbation and the code for pneumonia?

Answer: Yes, it is appropriate to assign both codes (J44.0 and J44.1). Either code may be sequenced first, based on the reason for the admission. Assign code J44.0, Chronic obstructive pulmonary disease with acute lower respiratory infection, code J18.9, Pneumonia, unspecified organism, and code J44.1, Chronic obstructive pulmonary disease with (acute) exacerbation. As stated in the ICD-10-CM Official Guidelines for Coding and Reporting in relation to category J44, “An acute exacerbation is a worsening or a decompensation of a chronic condition. An acute exacerbation is not equivalent to an infection superimposed on a chronic condition, though an exacerbation may be triggered by an infection.

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COPD Exacerbation with Pneumonia

ICD-10-CM/PCS Coding Clinic, 1st Q 2017 page 24 Effective with discharges: March 13, 2017

Question:

Does the advice published in Coding Clinic, Third Quarter 2016, pages 15-16, regarding chronic obstructive pulmonary disease (COPD) and pneumonia apply to all pneumonias, including aspiration pneumonia? Is the correct sequencing J44.0 and J69.0, in that order, or would the instructional note apply to aspiration pneumonia and COPD?

Answer: No, the instructional note at code J44.0, Chronic obstructive pulmonary disease, with acute lower respiratory infection, stating “Use additional code to identify the infection”, does not apply to aspiration pneumonia. The ICD-10-CM code for aspiration pneumonia does not fall in the “respiratory infection” codes. Code J69.0, Pneumonitis due to inhalation of inhalation of food and vomit, is under the section titled “Lung diseases due to external agents.” Aspiration pneumonia is an inflammation of the lungs caused by the inhalation of solid and/or liquid matter.
COPD Exacerbation with Pneumonia

Assign codes J44.9, Chronic obstructive pulmonary disease, unspecified, and J69.0, Pneumonitis due to inhalation of food and vomit, for a patient with chronic obstructive pulmonary disease and aspiration pneumonia. Sequencing of the two conditions will depend on the circumstances of admission.

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Note – as of 10/1/17, changes are being made to the ICD-10-CM tabular index and guidelines. Code J44.0 will no longer have to be sequenced first followed by a code for the lower respiratory infection.
Acute renal failure, Dehydration and Hyper/Hyponatremia

This is a 90-year-old female who was brought to the emergency room from the nursing home. The patient appears to have had low oral intake over the past several days. She appears to be severely dehydrated. She is in acute renal failure. She is hypernatremic. Labs reveal BUN 32, creatinine 2.7 and sodium 149. Her baseline BUN and creatinine are 22 and 1.0.

Plan: Acute renal failure with hypernatremia, presumed to be prerenal, aggressive hydration and blood chemistry every 6 hours. We will utilize normal saline for volume expansion at this point, and then switch to half-normal saline with D5 water.

Based upon this scenario, ICD-10 guidelines & Coding Clinic advice, what would you recommend as principal diagnosis?
Acute renal failure, Dehydration and Hyper/Hyponatremia

This was originally reported with dehydration as principal diagnosis. Acute renal failure and hypernatremia were secondary diagnoses. Recommendation made was to resequence and report acute renal failure as principal diagnosis.

This recommendation resulted in a change from MS-DRG 641/ 0.7221 to 683/ 0.9406.

There are two issues to discuss with this case. First, with ICD-10, when dehydration is present with hypernatremia or hyponatremia, codes are reported for both dehydration as well as hypernatremia or hyponatremia. This is discussed below in Coding Clinic, 1Q 14.
Acute renal failure, Dehydration and Hyper/Hyponatremia

Dehydration with hypernatremia or hyponatremia

ICD-10-CM/PCS Coding Clinic, 1stQ 2014 pg 7 Effective with discharges: March 31, 2014

**Question:** How should dehydration with hypernatremia and dehydration with hyponatremia be coded? Codes E87.0 and E87.1 seem to captures hypernatremia and hyponatremia respectively but not dehydration. There are no index entries for dehydration with hypernatremia/hyponatremia, and there is no subentry for dehydration within the entries of hyponatremia and hyponatremia.

**Answer:** Assign code E86.0, Dehydration, in addition to code E87.0, Hyperosmolality and hypernatremia, for a diagnosis of dehydration with hypernatremia. Assign code E86.0, Dehydration, in addition to code E87.1, Hypo-osmolality and hyponatremia, for a diagnosis of dehydration with hyponatremia. Two codes are required to fully capture dehydration with hypernatremia (E86.0 and E87.0) and dehydration with hyponatremia (E86.0 and E87.1). Coder should follow the index, which leads to coding both the dehydration and hypernatremia/hyponatremia separately.

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Acute renal failure, Dehydration and Hyper/Hyponatremia

The second issue is a reminder regarding past issues of AHA Coding Clinic. This is referring to the sequencing of principal diagnosis in this case. Rather than revising or deleting all the information in the previous issues of AHA Coding Clinic, an article was released 4Q 15 pp 20-21 which clarified the used of the older information. The portion of this article I am referring to states, “As far as previously published advice on documentation is concerned, documentation issues would generally not be unique to ICD-9-CM, and so long as there is nothing new published in Coding Clinic for ICD-10-CM and ICD-10-PCS to replace it, the advice would still stand.

Based upon the above information, Coding Clinic, 3Q 02 pg 21 was used as a reference to support the re-sequencing of this scenario.
Acute renal failure, Dehydration and Hyper/Hyponatremia

Acute renal failure due to dehydration

ICD-9-CM Coding Clinic, 3rd Qtr 2002, pg 21 Effective with discharges: October 31, 2002

**Question:** A patient is admitted with acute renal failure (ARF) due to severe dehydration. The patient is treated with IV fluids, and a renal ultrasound reveals atrophic right kidney. The patient slowly improves; however, the family does not want an aggressive workup and the patient is discharged to a hospice. What is the principal diagnosis in this case, ARF or dehydration?

**Answer:** Note from 3m: As of October 1, 2005, code 276.5 has been expanded to the 5th digit. Dehydration is coded to 276.51.

Assign code 584.9, Acute renal failure, unspecified, as the principal diagnosis. Acute renal failure was the reason for the admission. Code 276.5, Volume depletion, should be assigned as an additional diagnosis.

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Acute Renal Failure ??

Renal Consult – “REASON FOR CONSULT: Known to Nephrology Group, CKD stage 3. LAB DATA: BUN 28, creatinine around 1.6 to 1.8. ASSESSMENT: (1) Acute on chronic kidney disease stage 3…Acute renal failure due to volume changes…Attending Progress Note: “ASSESSMENT: Acute on chronic CKD 3…Discharge Summary: DISCHARGE DIAGNOSES: (1) Acute on chronic diastolic congestive heart failure; (2) Acute on chronic kidney disease III”

Do you see the issue with the above?

Acute renal failure is only documented by the renal consultant. The recommendation made is to query the attending provider due to the conflicting documentation.

Initial MS-DRG 292/ 0.9707. MS-DRG based upon chart documentation at this time, until query is obtained, 293/0.6737.
Acute Renal Failure ??

Documentation Issues from *Coding Clinic* (excerpted below)

ICD-10-CM/PCS Coding Clinic, 1st Q14, pgs 11-13 Effective with discharges: March 31, 2014

**Question:** Can you clarify whether advice on documentation issues that do not appear to be specifically tied to a particular coding system (ICD-9-CM nor ICD-10-CM/PCS) are still valid for ICD-10 or ICD-10-PCS?

**Answer:** *Coding Clinic* advice regarding documentation issues over the years has focused on what documentation can be used and was not specific to a coding system. For clarification purposes, the following information is being republished.

*Provider Documentation*

Code assignment may be based on other physician (i.e., consultants, residents, anesthesiologist, etc.) documentation as long as there is no conflicting information from the attending physician.
Acute Renal Failure ??

Medical record documentation from any physician involved in the care and treatment of the patient, including documentation by consulting physicians, is appropriate for the basis of code assignment. The issue of whether a resident’s documentation needs to be confirmed by the attending physician is best addressed by the hospital’s internal policies, medical staff bylaws, and/or other applicable local/state/federal regulations.

Documentation is not limited to the face sheet, discharge summary, progress notes, history and physical, or other report designed to capture diagnostic information. This advice refers only to inpatient coding.

It is appropriate to use the completed cancer staging form for coding purposes when it is authenticated by the attending physician.
Acute Renal Failure

It would be appropriate to use the health documentation of other providers, such as nurse practitioners and physician assistants as the basis for code assignments to report new diagnoses, if they are considered to be legally accountable for establishing a diagnosis within the regulations governing the provider and the facility. The Official Guidelines for Coding and Reporting define a provider as the individual legally accountable for establishing a diagnosis.

It is appropriate to assign a procedure code based on documentation by a nonphysician professional when that professional provides the service. This may be the only evidence that the service was provided. For example, infusions may be carried out by a nurse, mechanical ventilation may be provided by a respiratory therapist, or a drug may be ordered by the physician and administered by a nurse. Please note this only applies to procedure coding where there is documentation to substantiate the code. This advice does not apply to diagnosis coding…

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This 34 year old female presented with a perirectal abscess and cellulitis of the left buttock. She underwent incision and drainage in the OR on the second day of admission. She was then seen by Physical Therapy for pulse lavage of the wound (wound included deep subcutaneous tissue). She continued pulse lavage and IV antibiotics during her stay. After having a final pulse lavage, she was discharged home. Home Health was arranged for continued dressing changes.

The recommendation made was to add PCS code, 0JD90ZZ (Extraction of buttock subcutaneous tissue and fascia, open approach). The addition of this PCS code could potentially affect MS-DRG assignment if another OR PCS code had not already been reported.

The Coding Clinic previously discussed, 1Q14 pp 11-13, mentions to assign a procedure code based on documentation by a nonphysician professional as this may be the only evidence that the service was provided. This case is an example as PT was performing the pulse lavage. The coder at this particular client was not aware that they could report this code. The response was that they thought this was being captured by the charge master.
Question: The patient has chronic obstructive pulmonary disease (COPD) with asthma. Is code J44.9, Chronic obstructive pulmonary disease, unspecified, sufficient, or is an additional code needed for the asthma when the asthma is not further specified?

Answer: If the specific type of asthma is documented, assign an additional code for the asthma. If, however, the type of asthma is not further specified, do not assign code J45.909, Unspecified asthma, uncomplicated, separately. The instructional note under category J44, Other chronic obstructive pulmonary disease, states “code also type of asthma, if applicable (J45-). “Unspecified” isn’t a type of asthma.

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Question: Since an ileus does not always involve obstruction, should a diagnosis of postoperative ileus be assigned code K91.3. Postprocedural intestinal obstruction? Previously, postoperative ileus defaulted to a complication code. However, in ICD-10-CM, there is no default code assignment for postoperative ileus.

Answer: Query the physician to determine if the ileus is a postoperative complication. If the physician confirms that the ileus is a postoperative complication, assign code K91.89, Other postprocedural complications and disorders of digestive system. Code K56.7, Ileus, unspecified, should be assigned as an additional diagnosis to describe the specific complication. If, however, after query, the physician confirms that the ileus is not a surgical complication, assign only code K56.7. Only assign code K91.3, Postprocedural intestinal obstruction, for an obstructive ileus that the physician has documented as a post-op complication.
Pg 51 – Bronchoalveolar Lavage

_Coding Clinic_, First Quarter 2016, page 26, contained an error regarding the appropriate ICD-10-PCS code for bronchoalveolar lavage (BAL). Code 0B9B8ZX, Drainage of left lower lobe bronchus via natural or artificial opening endoscopic, is not the correct code. BAL involves washing out and sampling alveoli of the lung (small sacs within the lungs). The appropriate code assignment for a BAL is as follows:

0B9J8ZX – Drainage of left lower lung lobe, via natural or artificial opening endoscopic, diagnostic

The lung body part values more accurately capture the objective of bronchoalveolar lavage, and coding to the lung is consistent with the general PCS convention of coding treatment of a tubular body part to the furthest anatomical site reached. In this case it is alveolar (lung) tissue.

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The RIFLE classification was developed as a means to create a uniform, acceptable definition of AKI (Acute Kidney Injury).

The RIFLE criteria are defined as changes within 7 days and the acronym stands for:

R: Risk
I: Injury
F: Failure
L: Loss
E: End-stage renal disease

### RIFLE Classification for AKI

**RIFLE criteria for classification for acute renal failure**

<table>
<thead>
<tr>
<th>Risk</th>
<th>Increased creatinine x 1.5 or GFR decrease &gt; 25%</th>
<th>UO &lt;0.5 ml kg (-1) h (-1) x 6 h</th>
</tr>
</thead>
<tbody>
<tr>
<td>Injury</td>
<td>Increased creatinine x 2 or GFR decrease &gt; 50%</td>
<td>UO &lt;0.5 ml kg (-1) h (-1) x 12 h</td>
</tr>
<tr>
<td>Failure</td>
<td>Increased creatinine x 3 or GFR decrease &gt; 75% or creatinine &gt; 4mg per 100 ml (acute rise of &gt; 0.5 mg per 100 ml dl)</td>
<td>UO &lt;0.5 ml kg (-1) h (-1) x 24 h or anuria x 12 h</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Loss</th>
<th>Persistent ARF = complete loss of renal function &gt; 4 weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>ESRD</td>
<td>End-stage renal disease</td>
</tr>
</tbody>
</table>
KDIGO Classification for AKI

KDIGO is an acronym for the Kidney Disease Improving Global Outcomes and consists of clinical practice guidelines based upon RIFLE and AKIN (another classification system) criteria.

KDIGO defines AKI as any of the following:

- Increase in serum creatinine by 0.3 mg/dL or more within 48 hours or
- Increase in serum creatinine to 1.5 times baseline or more within the last 7 days or
- Urine output less than 0.5 mL/kg/h for 6 hours
The KDIGO has also recommended a staging system for the severity of AKI.

The role of KDIGO is to aid in the “development, dissemination and implementation of clinical practice guidelines in the field of AKI.”


Sepsis has always been difficult to code and report correctly. There are many articles in Coding Clinic referring to bacteremia, septicemia, sepsis, septic shock.

Coding Clinic, 2Q 00 pp 3-4 states “Sepsis syndrome comprises septicemia with evidence of inadequate organ perfusion with at least some degree of one or more of the following: hypoxemia (Pa02<75 mmHg); elevated lactate (>5 meq/L); oliguria (<30mL/hr urine); altered mentation (Glasgow coma score); disseminated intravascular coagulopathy (DIC); decreased platelets; increased INR; and/or fibrin split products (FSP).”

SIRS (Systemic Inflammatory Response Syndrome) is characterized by fever, leukocytosis, tachycardia, tachypnea.
As HIM coding professionals, we have the above clinical indicators to stand behind. Over the years in the non-HIM world, there have been different definitions of sepsis. The most current definition/criteria is the 2016 Sepsis-3. Per a recent article in CDI Strategies (Vol 11, Issue 5), these guidelines were published in the March 2017 issue of Critical Care Medicine as they have adopted the definition as “life-threatening organ dysfunction caused by a dysregulating host response to infection” discarding the Sepsis-2 definition of sepsis as Systemic Inflammatory Response Syndrome (SIRS) due to infection. IT NOW MAKES NO DISTINCTION BETWEEN SEPSIS AND SEVERE SEPSIS…”

Sepsis-3 defines organ dysfunction as an increase in the total Sequential Organ Failure Assessment (SOFA) score by 2 point or more from baseline.
Sepsis 3 SOFA Clinical Criteria

Sepsis-3 defines organ dysfunction as an increase in the total Sequential Organ Failure Assessment (SOFA) score by 2 point or more from baseline.

SOFA classifies 6 organ systems on a scale from 0 to 4 points using objective measures:

- 1 ==== Respiratory : pO2/FIO2 ratio
- 2 ==== Coagulation : Platelet count
- 3 ==== Liver : Bilirubin
- 4 ==== Cardiovascular : Mean arterial pressure or vasopressors
- 5 ==== Central Nervous : Glasgow coma scores
- 6 ==== Renal : Creatinine or urine output
Sepsis 3 SOFA Clinical Criteria

The article from CDI Strategies, Vol 11 Issue 5 goes on to state that the CMS Hospital Inpatient Quality Reporting (IQR) severe sepsis management measure that is being abstracted by hospital quality departments, defines sepsis as SIRS due to an infection. They recommend that hospitals should make sure medical staff leadership is “engaged with this complex challenge” of reconciling these guidelines. Also, CDI and coding professions should begin using these Sepsis-3 and SOFA criteria for queries and clinical validation. Most important, keep in mind that the Sepsis-3 definition requires acute organ dysfunction as part of the definition of sepsis. Therefore, all cases which meet the sepsis-3 definition would apparently be coded as severe sepsis.

Below are three additional sources which discuss this updated definition of sepsis:

http://www.sccm.org/Research/Quality/Pages/Sepsis-Definitions.aspx


http://rebelem.com/sepsis-3-0/
Closing

Recap:

In this presentation, we discussed actual inpatient cases from recent client reviews in which recommendations were made based upon ICD-10 code changes along with supportive documentation from Coding Clinic. Many more could have been presented as it seems there is still potential for coding education at most of our client sites.

We discussed the RIFLE criteria for acute kidney failure as well as the KDIGO classification system.

We also discussed the latest definition of sepsis: Sepsis-3 and the SOFA clinical criteria.

Any remaining time was spent answering audience questions/comments.