Tips to avoid adding insult to 'injury' documentation

by Robert S. Gold, MD

During the past few years, we have seen the evolution of certain terms in the medical literature, most of which have evolved from recent professional writings. One of the most recent is the term “injury,” which is causing headaches in CDI programs and is hurting disease data streams.

Acute brain injury, acute lung injury (ALI), and acute kidney injury (AKI) were introduced into the vocabulary in an effort to help clinicians identify patients with mechanisms of organ damage that require study, treatment, and intervention. Each one of these afflictions can have a wide variance of reversible outcomes or result in total organ destruction and death.

The problem is that the verbiage related to these “injuries” does not coincide with existing ICD-9-CM terminology, nor does it satisfy the desire of the Society and the National Centers of Health Statistics to help track disease, so the outcomes are becoming completely destructive.

Why? Because neither side—physicians or coders—recognizes that it speaks a different language. Both sides think they are being helpful, but they aren’t helping at all.

Dialogue digression

Here’s an example: A coder recognizes the acronym CC as a complication or comorbid condition. However, physicians recognize the same term as an abbreviation for the patient’s chief complaint.

Both acronyms appear in medical records. Both are part of documentation, coding, and billing for services. Each participant in the dialogue knows what he or she is talking about when using the term. But neither participant really understands the implications of what the other party is saying. The dialects simply don’t jive.

Okay, maybe that’s a bit of a stretch. It’s somewhat easy to see that a CC can mean different things. After all, a pulmonologist refers to acute respiratory failure as ARF and a nephrologist refers to acute renal failure as ARF, but everyone can figure out what’s going on from the context of the documentation, right? But what happens when an internist uses the term ARF? In this case, it may be difficult to determine what he or she is talking about without further investigation.

Analogous affirmation

In critical care medicine, the term “injury” has been used to describe intrinsic damage to an organ with reversible or irreversible outcomes.

Almost all critical care studies have taken place in critical care units where the patients are already presumed to be critically ill.

However, ICD is a system of pathogenesis—the path and origin of a disease. Therefore, ICD does not necessarily represent the same language used in critical care medicine. These are different entities, and they do not talk to each other.

ICD is a system whereby severity of illness and risk of mortality can be computed based on etiology of a presentation of a healthcare concern. The term “injury” is descriptive of presentation and has nothing to do with severity of illness or risk of mortality—in fact, the severity of these injuries can be anywhere across the board, and using the term with the expectation of risk adjustment calculations derived from statistics is ludicrous.

Yet the term “injury” is used in emergency departments, med-surg nursing units, gastrointestinal labs, and outpatient clinics, and these patients are not all presumed to be critically ill.

Typifying terminology

Physicians use the term “injury” based on writings in the current literature and do not investigate alternative definitions. But when original studies are performed in one environment and the terminology is used in a secondary or tertiary environment, the terminology becomes distorted and data derived from its use become inaccurate.

For example, when studies on the concept of ALI involve patients on ventilators, then certainly we can classify all patients with ALI as having acute respiratory failure. When all cases of ALI in critical care units have intrinsic lung damage, causing the need for a ventilator, ALI implies a critically ill patient.
Fortunately, since the origination of the term ALI, further studies have shown that all patients with adult respiratory distress syndrome (ARDS) have ALI. (See “Documentation specificity needed for ALI and ARDS” at right.) That reflects direct damage to the lungs due to trauma, sepsis, or some process that directly damages respiratory tissue.

However, not all ALI patients have ARDS. Only 23% of patients on ventilators because of acute respiratory failure have ALI. The other 77% have primary heart disease rather than primary lung damage, or brain trauma and not primary lung damage, or many other causes that do not result in primary lung damage.

See what I mean? In this case, if the physician documented using the term “acute respiratory failure,” he or she covers all the bases, accurately communicating the patient’s condition. Conversely, documenting ALI or ARDS only covers the patient population on ventilators because of acute respiratory failure that have been defined as due to direct lung damage.

My recommendation? Ask physicians to document “acute respiratory failure due to sepsis-related ARDS” or “acute respiratory failure due to acute lung injury from pulmonary contusion.” Then ask them to describe the outcome and the cause. Correct coding with ICD depends on pathogenesis.

**AKI controversy**

A similar situation arises when CDI specialists review a chart and encounter AKI patients on critical care units. If all cases of AKI in critical care units have intrinsic renal damage causing the concern and possible need for acute dialysis, then AKI implies a critically ill patient.

However, AKI is also used for patients with problems other than intrinsic renal damage. For example, some healthcare staff members use the term in reference to the prerenal patient with excessive fluid losses who has decrease in glomerular filtration but who has not suffered significant enough intrinsic renal damage to be considered as acute renal failure. It’s inappropriate to use the term AKI for these patients.

We see physicians that document AKI in patients with post-obstructive uropathy with elevations of creatinine who, with insertion of a urinary catheter, revert to normal renal function within hours without measurable intrinsic damage to the kidney parenchyma. It’s inappropriate to use AKI for these patients.

The origination of the RIFLE criteria (i.e., risk, injury, failure, loss, and end-stage kidney disease), with its three levels of severity of measurement of function and its two levels of prolonged effect on renal function, was directed toward the term “acute renal failure.” This term has always included prerenal, intrarenal, and postrenal causes. When the Society for Critical Care Medicine’s publications adopted the use of the RIFLE criteria, they studied its effects and its potential for mortality on critical care units where all of the patients had intrinsic renal damage.

But not all patients with acute renal failure are on a critical care unit. Not all of them need to be on a critical care

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**Documentation specificity needed for ALI and ARDS**

Using the term “acute respiratory failure” covers all the bases. Documenting acute lung injury (ALI) or adult respiratory distress syndrome (ARDS) only covers the patient population on ventilators because of acute respiratory failure that have been defined as due to direct lung damage.

Source: DCBA, Inc.
Documentation
continued from p. 9

unit. Also, many of them are not critically ill, particularly those with prerenal and postrenal causes.

Finally, if a physician uses the term AKI when the patient does not meet any of the RIFLE criteria, he or she could simply be stating that there was kidney damage or abnormalities in renal function tests resulting from a different cause.

Go back to the days of yesteryear, when the term “acute renal failure” implied just that—and if you want to go further, identify the specificity of the cause when you can. Describe the link of pathogenesis in such ways as “acute renal failure due to severe dehydration from fluid losses in clostridia enterocolitis,” or “acute renal failure due to AKI from acetaminophen toxicity.” Let the term be the driving force.

Resolving differences

If physicians in your hospital use the term AKI, what should a CDI specialist do?

I’d suggest they encourage documentation of acute renal failure, supply their physicians with the RIFLE criteria from a publication that refers to it as “acute renal failure,” and accept the fact that physicians might document AKI. The CDI specialist should check whether the patient has met the minimum RIFLE requirements before coders assign 584.9. If the patient’s renal function does not meet the criteria, coders should not translate AKI into 584.9 without specific documentation by the physician stating why he or she thinks the patient meets AKI. (See “Determine CKD by GFR or creatinine level” at left.)

Acute brain injury is probably the only “injury” category in which the intrinsic brain damage (whether through direct trauma or through indirect chemical damage such as ischemia or circulating toxins) is the only way that damage occurs with no corresponding “acute brain failure” to consider. Even here, the term “acute brain injury” does not tell the story as needed by ICD, which is a system for pathogenesis and severity of illness.

When a patient has a concussion, cerebral contusion, intracerebral bleed, or subarachnoid hemorrhage due to parietal bone skull fracture, the pathogenesis is key. However, when the patient was comatose for an hour, for 24 hours, or with no hope of recovering consciousness; or when the patient has cerebral edema or herniation of the brain or is being placed on comfort measures and withdrawal of life support, it’s these other terms that tell the story for severity.

What’s the bottom line? The term “injury” (except in instances of trauma) is frequently misused, leading to misconception and mistakes. This affects everything from severity of illness to patient data and epidemiological tracking capabilities.

Until we have injury stages and descriptive mechanisms—something that even ICD-10 doesn’t yet include—I recommend using the standard terminology and linking the outcome to the cause.

Editor’s note: Dr. Gold founded DCBA, Inc., in Atlanta, a consulting firm that provides physician-to-physician programs in CDI. The goals are data accuracy, profile management, and compliance in the inpatient and outpatient arenas. He can be reached by phone at 770/216-9691 or by e-mail at DCBAINC@cs.com.

Determine chronic kidney disease by glomerular filtration rate or creatinine level

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<th>ICD-9-CM code</th>
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<th>GFR</th>
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Sources: National Kidney Foundation, ICD-9-CM, and CMS. Creatinine levels based on 65-year-old 170-lb. white male.