Audit present-on-admission indicators to ensure compliance, data accuracy

Was it present on admission (POA) or did it develop during the patient’s stay?

These days, this question has become part of an inpatient coder’s mantra, and rightly so. Not only does the POA indicator affect data related to patient safety indicators and quality-of-care measures, it also has the potential to alter hospital reimbursement—in a big way.

Consider the following example: A patient is admitted due to acute atrial fibrillation. On the sixth day of admission, the patient develops a stage III pressure ulcer. A coder assigns POA indicator N for the pressure ulcer. Before implementation of the POA, this case would have mapped to MS-DRG 308 (relative weight 1.2188). Today, however, it maps to MS-DRG 310 (relative weight 0.5710) because the patient developed the ulcer in the hospital after the inpatient admission order was written.

CMS’ rationale is to promote financial penalties for certain conditions that develop after admission, says Gloryanne Bryant, RHIA, RHIT, CCS, CCDS, regional managing director of HIM, NCAL revenue cycle, at Kaiser Foundation Health Plan, Inc. & Hospitals in Oakland, CA. The hope is that this will lead to higher quality of care for preventable conditions, says Bryant.

What does this mean for hospital coders? “POA surveillance is going to be critical,” says Bryant. “Auditing, data mining, knowing the rules, and involving a multidisciplinary group of staff members to look at the data is going to be very important.”

Target problematic conditions

Coders should always be on the lookout for clinical details that lead to correct POA assignment, says James S. Kennedy, MD, CCS, director at FTI Healthcare in Brentwood, TN. “HIM professionals need to put on their clinical thinking cap. [They] have a profound responsibility in working with the medical staff to make certain that [the indicators] are clinically congruent,” Kennedy says.

For example, not all physicians know that hyperosmolar diabetes exists when blood sugar is above 550–600 mg/dl, says Kennedy. As a result, many don’t document the condition until after admission, which may result in incorrect POA assignment (i.e., N or U instead of Y), when the patient actually had the condition on admission.

This is also true for acute renal failure or acute kidney injury (AKI). Some physicians don’t know that these...
POA indicators  < continued from p. 1

conditions are present when there is an abrupt rise of serum creatinine (of more than 0.3 mg/dl) or fall in urine output (to less than 0.5 ml/hour) for more than six hours, says Kennedy. As a result, it may not be documented until later in the stay. Kennedy provides the following example of a compliant query for AKI: “The patient’s creatinine on admission was 2.0. After hydration, it fell to 1.0. AKI was documented on day three. Was the AKI POA?”

Similarly, some physicians may not document whether a patient had a pressure ulcer on admission, or they may simply say “skin within normal limits,” which doesn’t indicate whether a skin assessment for pressure ulcers was even performed, says Kennedy.

Postoperative sepsis is problematic due to its sometimes subjective clinical criteria and vague definition, says Kennedy. Clinical indicators of sepsis usually include tachycardia, tachypnea, leukocytosis, fever, hypothermia, or organ dysfunction; however, a seasoned physician must also validate that the patient is systemically ill or septic.

Physician documentation must reflect whether the sepsis is POA, and the physician must link it to an underlying infection. Physicians commonly document sepsis with uncertainty (e.g., rule out sepsis or possible sepsis), says Kennedy, adding that some physicians label patients as septic based on fever and an elevated white blood count even when the patient doesn’t appear sick.

Coders should discuss clinical indicators with physicians to try to generate congruence regarding a septic presentation, says Kennedy. Use this guide as a starting point: http://tinyurl.com/sepsisguide.

Remember that sepsis may not be reported as a principal diagnosis unless it is POA, says Kennedy. “When you report 038.9 as a principal diagnosis with a U or N indicator, this will be a red flag for retrospective auditors,” he explains. “The question will be, ‘Why did you sequence it as principal when you weren’t sure whether it was POA?’ ”

When documentation is unclear regarding whether the sepsis is POA, coders should query for more information. Using a yes-or-no question to determine the time of onset is permissible, Kennedy says. Also remember that an uncertain diagnosis may not be coded unless a physician documents it at the time of discharge.

Proceed one step at a time

Developing a tool or worksheet that compares original POA assignment with the POA indicator that was deemed appropriate after additional review of physician documentation is the first step in auditing POA data, says
Bryant. Ensure that your tool captures the reason for the variance, such as incorrect indicator, lack of indicator, or lack of documentation. The tool also should include appropriate demographic information, a summary of findings, and recommendations (including a corrective action plan with a timeline and responsible individuals). Tracking the financial impact of POA variances, when applicable, is also useful. Your tool should include a comparison of the original DRG (with relative weight) and the revised DRG (with relative weight).

Bryant and Kennedy suggest that providers ask the following questions, among others, when analyzing POA data:

➤ Do we have a representative sample size? Use a manageable number of claims (minimum of 100 cases) as a baseline, and include cases from all coding staff.

➤ What are the top 20 cases or MS-DRGs reported with the N indicator? Does sufficient documentation exist to support N indicators, or should coders have queried for more information?

➤ Do any of the exempt codes include a POA indicator of U, W, Y, or N? Per POA guidelines, exempt codes should only include a ‘1’ or be left blank. Access the guidelines at www.cdc.gov/nchs/data/icd9/icdguide09.pdf.

➤ Do any of our chronic conditions include an N or W indicator? According to POA guidelines, chronic conditions should always be reported with a Y.

➤ Are we correctly transferring the POA indicator to the UB-04 claim?

➤ Are we under-reporting any of our POA indicators? What do previous audits reveal? What prior coding education have we provided related to current auditing findings? What additional education do we need?

➤ Should we perform a follow-up audit? These audits typically are conducted three to four months after the original audit and include patterns and high-risk areas determined during the initial audit, says Bryant.

Editor’s note: This article was adapted from HCPro’s January 22 audio conference, “Audit POA Indicators: Ensure Accuracy, Quality Data, Compliance, and Understand the Payment Implications.” For more information, visit www.hcmarketplace.com/ prod-8251/Audit-POA-Indicators.html.

The quick list

Seven tips to keep your coding compliance program fresh

Just because your coding compliance program is in place doesn’t mean it’s doing its job effectively. The following are tips from three industry experts on preventing your program from becoming stagnant:

1. Assess and update your compliance program annually. Review the annual OIG Work Plan to identify areas of new or renewed scrutiny. Share your findings with senior leadership and the governing board to ensure enterprise-wide buy-in and top-down support.

2. Provide concrete examples. During compliance training sessions, explain how employees’ work affects their organization’s liability and fiscal health. Don’t hesitate to share worst-case scenarios of facilities that close their doors because of noncompliance with CMS rules and regulations.

3. Collaborate with other departments. Risk management, performance improvement, the revenue cycle, and finance departments should work together to identify or detect new risk areas that affect coding compliance. It’s also important for the coding staff to communicate with the medical staff and provide feedback regarding whether documentation supports code assignment.

Dinh Nguyen, principal at Healthcare Compliance Solutions, LLC, in Los Angeles, provided the previous three tips.

4. Continually assess coders’ clinical knowledge. Consider administering clinical coding exams that incorporate unusual case studies and atypical presentations of different disease processes. Coders must understand a variety of disease processes and the significance of

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abnormal laboratory values and the treatment, management, and workup of diseases.

5. **Develop and implement a clinical training program.** The program should address and correct coding staff members’ clinical knowledge deficiencies. Tailor the program to meet individual staff members’ needs. Enhancing coders’ clinical knowledge is important because a significant number of coding oversights and errors identified during the RAC demonstration program pertained to misinterpretation of clinical documentation.

   Greater clinical knowledge also will help coders know when a query is necessary and ensure correct assignment of the principal diagnosis and all relevant secondary diagnoses.

   *Glenn Krauss, RHIA, CCS, CCS-P, CPUR, an independent coding consultant in Milton, WI, provided the previous two tips.*

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**Understanding circulatory system anatomy will help you prepare for coming conversion to ICD-10-CM/PCS**

Dust off a medical terminology book and start reviewing anatomy and physiology. This may be the best advice for coders as they prepare for ICD-10-CM and ICD-10-PCS, experts say.

Coders shouldn’t underestimate the breadth of anatomy, physiology, and medical terminology they’ll need to know to code properly under the new system, says *Shelley C. Safian, MAOM/HSM, CCS-P, CPC-H, CPC-I, CHA*, president of Safian Communications Services, Inc., in Orlando, FL.

Some coding programs simply don’t place sufficient emphasis on these content areas that will essentially become the foundation for compliant coding under ICD-10-CM and ICD-10-PCS, says Safian.

When the coding update finally becomes effective October 1, 2013, this lack of emphasis may become a major problem—and negatively affect coding compliance, she explains.

Even though ICD-10-CM and ICD-10-PCS will require coders to extract more anatomical details from physician documentation, the anatomy that coders must understand for the new coding system is not all that different from what they must know today, says Safian. “We have to remember that there are still only 206 bones in the body. ICD-10-CM and ICD-10-PCS didn’t invent more arteries and veins. You just have to know more detail,” she explains.

The new codes present greater challenges than coders have experienced with ICD-9-CM. Assigning a code in ICD-10-CM or ICD-10-PCS without having greater in-depth knowledge of the anatomy to which the condition or procedure pertains will be virtually impossible, says *William E. Haik, MD, FCCP*, director of DRG Review, Inc., in Fort Walton Beach, FL. ICD-9-CM is often vague, thereby allowing “coders to skate through without having to really understand anatomy,” Haik says.
But where does one begin when tackling the daunting task? The circulatory system is a good place to start when reviewing anatomy and physiology because ICD-10-CM diagnosis and ICD-10-PCS procedure codes in this content area tend to be particularly anatomically driven, says Darren Carter, MD, president and CEO of Provistas in Bismarck, ND. “It’s pretty substantially different [from ICD-9-CM],” Carter says.

Understanding the brain’s anatomy, the arteries and nerve conduction of the heart, the cerebrovascular arteries, and circulation of blood flow through the heart can help ensure correct code assignment both now and particularly when the new system becomes effective.

Know how to code intracerebral hemorrhages

In ICD-10-CM, many conditions will rely more heavily on anatomical specificity. For example, in ICD-9-CM, code 431 denotes an intracerebral hemorrhage, a type of intracranial hemorrhage that occurs within the brain tissue. However, when assigning this condition in ICD-10-CM, coders first must distinguish between traumatic and nontraumatic hemorrhages. Report traumatic hemorrhages (e.g., those due to brain trauma) with a code from the S06 category. Report nontraumatic hemorrhages (e.g., those due to spontaneous strokes) with one of nine codes in the I61 category that distinguish between the specific area of the brain in which the hemorrhage occurred. For example, report I61.0 for an intracerebral hemorrhage in the subcortical hemisphere. Report I61.3 for an intracerebral hemorrhage in the brain stem. Report I61.4 for an intracerebral hemorrhage in cerebellum.

“From a research standpoint, [this information] is invaluable,” says Carter. ICD-10-CM generally will allow researchers to track and analyze such data points as sequelae of particular diseases, recoveries, age-related variables, underlying diseases, and more, he explains. More detailed anatomical information may also lead to a better understanding of how costs relate to the intensity of care required for particular conditions. “It’s possible that some of these distinguishing characteristics may come into play with future MS-DRGs,” he says.

Know how to code atherosclerosis

Atherosclerosis, or hardening of the arteries, is another condition that requires greater anatomical specificity. For example, ICD-9-CM maps atherosclerosis of the native arteries of the extremities (including arms and legs) to code category 440.2. In ICD-10-CM, coders can report one of several codes in the I70.2 category that distinguish between the left leg, right leg, bilateral legs, or other extremities. Both ICD-9-CM and ICD-10-CM require coders to identify other concurrent problems, such as pain at rest, ulceration, gangrene, and claudication (i.e., tightness and pain in the calves when walking).

Consider these tips

The following tips can help build a more solid foundation of anatomical knowledge:

➤ Accumulate educational resources. There’s no time like the present to start building a library of medical dictionaries, anatomy books, and online courses to which you can refer now and in the future, says Safian. Use these resources now when reading operative reports to start learning more about the procedures and conditions detailed in physician documentation.

➤ Start practicing. Review the current draft of ICD-10-CM and ICD-10-PCS to determine which conditions and procedures will require additional documentation. If you tend to code a particular specialty, such as diseases of the circulatory system, focus on those sections of the ICD-9-CM Manual to note the differences between the two coding systems.

➤ Get physicians on board. “Most physicians don’t even realize that [ICD-10-CM] is happening. They probably don’t know ICD-9-CM all that well and have no idea how extensively different ICD-10-CM and ICD-10-PCS will be,” says Carter.

Hospitals that already focus on documentation improvement may find it easier to persuade physicians to provide documentation that more closely aligns with ICD-10-CM and ICD-10-PCS code descriptions. “It takes a while to build a habit. Now is the time to start inching

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Understand anatomy < continued from p. 5

[physicians] toward that information,” says Safian. For example, ask physicians who don’t typically document the approach of certain procedures or the type of tissue used for a graft to get in the habit of doing so now.

Safian advises focusing on three important factors when obtaining physician buy-in:

– The federal government requires providers to change to ICD-10-CM/PCS. This is not voluntary.
– The two systems differ substantially with respect to code assignment logic.
– Be certain that physicians are aware of changes that may affect documentation and the types of queries they receive.

➤ Tap into physician knowledge. For example, schedule an appointment to have the physician explain the mechanics of performing a coronary artery bypass, suggests Safian. Not only does this open the lines of communication, it also helps build mutual respect, provides a rapport for future queries, and enhances continuity of care.

Case study: Getting to know ICD-10-CM/PCS

It’s never too early to start reviewing anatomy, physiology, and other details in the record to prepare for ICD-10-CM and ICD-10-PCS. Shelley C. Safian, MAOM/HSM, CCS-P, CPC-H, CPC-I, CHA, president of Safian Communications Services, Inc., in Orlando, FL, provides a case study that compares ICD-9-CM diagnosis and procedure coding with ICD-10-CM diagnosis and ICD-10-PCS procedure coding for a patient with coronary artery disease who presents for a coronary artery bypass.

Diagnosis coding in ICD-9-CM

1. Report 414.01 (coronary atherosclerosis of a native coronary artery), which is a complete code.
2. Use an additional code, when applicable, to identify chronic total occlusion of the coronary artery (414.2).

Procedural coding in ICD-9-CM

1. Report 36.1x, depending on the number of coronary arteries bypassed.

Diagnosis coding in ICD-10-CM

1. Report I25.1 (atherosclerotic heart disease); however, this is not a complete code. Coders also must determine whether the patient has angina pectoris, and if so, whether it is unstable, with documented spasm, unspecified, or in another form.
2. Use an additional code, when applicable, to identify chronic total occlusion of the coronary artery (I25.82).

3. Use an additional code, when applicable, to identify:
   – Exposure to environmental tobacco smoke (Z58.7)
   – History of tobacco use (Z87.82) occupational
   – Exposure to environmental tobacco smoke (Z57.31)
   – Tobacco dependence (F17)
   – Tobacco use (Z72.0)

Procedural coding in ICD-10-PCS

Note that ICD-10-PCS codes follow a seven-character structure that details the following: section, body system, root operation, body part, approach, device, and qualifier.

1. Start with a base code of 021. The ‘0’ refers to the medical and surgical section. The ‘2’ refers to the heart and great vessel body system. The ‘1’ refers to the bypass root operation. ICD-10-PCS defines a bypass as “altering the route of passage of the contents of a tubular body part.”
2. Determine the body part (i.e., coronary artery [one, two, three, or four or more sites] or right atrium).
3. Determine the approach (i.e., open, percutaneous, or percutaneous endoscopic).
4. Determine the device (i.e., autologous venous tissue, autologous arterial tissue, synthetic substitute, nonautologous tissue substitute, drug-eluting intraluminal device, intraluminal device, or no device).
5. Determine the qualifier (i.e., coronary artery, internal right mammary, internal left mammary, thoracic artery, abdominal artery, aorta, coronary vein, pulmonary trunk, pulmonary right artery, pulmonary left artery, or left atrium).
Audit wound debridement MS-DRGs before your RAC does

Coders don’t need a RAC audit to tell them that reporting inpatient wound care is particularly challenging. The culprit is typically lack of documentation to support excisional versus nonexcisional debridement of a wound, infection, or burn. Important details include the following information:

➤ The site of the wound, burn, or infection  
➤ The type of instrument used to perform the debridement  
➤ The depth of the debridement

Excisional debridement (ICD-9-CM procedure code 86.22) refers to the surgical removal or cutting away of devitalized tissue, necrosis, or slough. The procedure may be performed in an operating room, emergency room, or at the patient’s bedside, depending on the availability of a surgical suite as well as the extent of the area to be debrided. Nurses, therapists, physician assistants, or physicians may perform excisional debridement; however, when nonphysician practitioners perform it, they must report 86.22. (See Coding Clinic, Fourth Quarter 2004, pp. 138-139 effective with discharges January 31, 2005.)

Nonexcisional debridement (ICD-9-CM procedure code 86.28) is the nonoperative brushing, irrigating, scrubbing, or washing of devitalized tissue, necrosis, or slough. During this procedure, a provider snips tissue and then provides Hubbard tank therapy. The provider may also remove loose fragments from the wound with scissors. Physicians or nonphysician providers may perform nonexcisional debridement.

Debridement has been the subject of industry attention for quite some time, but RAC audits have brought the procedure even further into the spotlight, says Gloryanne Bryant, RHIA, RHIT, CCS, CCDS, regional managing director of HIM, NCAL revenue cycle, at Kaiser Foundation Health Plan, Inc. & Hospitals in Oakland, CA. This is also a frequent topic in AHA's Coding Clinic. See p. 8 for relevant references that coders can use as a guide.

CMS reports in its FY 2006 RAC Status Document that it has collected $3.9 million in overpayments related to DRG 263 (Skin graft and/or debridement for skin ulcer or cellulitis). It also has collected $13.9 million in overpayments related to DRG 217 (Wound debridement and skin graft, exc. hand for musculoskeletal and connective tissue disease).

More recently, RACs in the permanent program have begun looking at 86.22 as part of their complex DRG validation audits. For example, Connolly Healthcare (Region C) has approved validation of MS-DRGs 901 (Wound debridements for injuries with MCC), 902 (Wound debridement for injuries with CC), and 903 (Wound debridements for injuries without CC or MCC). HealthDataInsights (Region D) also has included each of these three MS-DRGs in its list of more than 60 MS-DRGs eligible for validation.

Standard language posted on HealthDataInsight’s Web site for each of its DRG validation issues states in part:

DRG validation requires that diagnostic and procedural information and the discharge status of the beneficiary, as coded and reported by the hospital on its claim, matches both the attending physician description and the information contained in the beneficiary’s medical record.

Although these MS-DRGs aren’t currently subject to medical necessity reviews, Bryant says once RACs begin assessing for necessity, providers had better pay attention. Debridement may be one of many procedures performed during a hospital stay, and during a medical necessity review, the entire record is fair game, she explains. “Although a particular DRG, diagnosis, or procedure would trigger a RAC to look at a record, now the whole record is open to scrutiny,” she says.

Bryant suggests considering these tips when preparing for RAC audits related to inpatient wound care:

➤ Don’t make assumptions. One common assumption is that physicians performed excisional debridement when they used scissors. This may not be the case, says Bryant. Scissors simply may have been used

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Wound debridement  
< continued from p. 7

to cut away the loose fragments. Similarly, a scalpel may or may not indicate excisional debridement.

➤ Conduct proactive audits. Don’t wait for a RAC to knock on your door before you implement a compliance plan, says Bryant. Proactive audits should target cases in which patients underwent excisional debridement (86.22), because this is the surgical procedure that drives each MS-DRG currently under review. Select at least 100 cases if your volume is that significant, says Bryant. If your volume is fewer than 100 cases, audit them all, she adds. Ensure that documentation supports the code billed and meets Coding Clinic guidelines. Hospitals also should consider auditing cases from a diagnosis perspective using specific diagnoses that typically warrant some type of inpatient wound care. These diagnoses include cellulitis, burns, diabetic ulcers, post-surgical wounds, arterial wounds, and other wounds that resist healing.

➤ Provide ongoing coder education. Review and share any requests for complex reviews related to inpatient wound care services, says Bryant. Use these requests as an educational tool during coder team meetings. “Even though you cannot and should not manipulate, change, or addend anything, it’s important to know if you’ve got problems so you can perform future audits and put a corrective action plan in place,” she says.

Know these important Coding Clinic inpatient wound debridement references

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<thead>
<tr>
<th>Inpatient wound debridement is a frequent topic of discussion in AHA’s Coding Clinic. Gloryanne Bryant, RHIA, RHIT, CCS, CCDS, regional managing director of HIM, NCAL revenue cycle, at Kaiser Foundation Health Plan, Inc. &amp; Hospitals in Oakland, CA, advises coders to review the following references to ensure compliance.</th>
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<td><strong>Fourth quarter 2008</strong></td>
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<tr>
<td>➤ Excisional versus mechanical debridement</td>
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<td><strong>Third quarter 2008</strong></td>
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<td>➤ Debridement associated with incision and drainage</td>
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<td>➤ Wound debridement of coccyx</td>
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<td>➤ Documentation guidelines for excisional debridement</td>
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<td>➤ Documentation of sharp debridement</td>
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<td><strong>Second quarter 2005</strong></td>
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<td>➤ Excisional debridement of sites not listed in index</td>
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<td><strong>First quarter 2005</strong></td>
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<td>➤ Debridment for amputation site infection and cellulitis</td>
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<td><strong>Second quarter 2004</strong></td>
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<td>➤ Clarification regarding whether a sharp instrument indicates excisional debridement was performed</td>
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<td><strong>Second quarter 2004</strong></td>
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<td>➤ How to report pulsed lavage digressive debridement</td>
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<td><strong>First quarter 2003</strong></td>
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<td>➤ Outpatient observation for monitoring/dressing changes after MVA</td>
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<td><strong>Second quarter 2000</strong></td>
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<td>➤ Clarification for reporting excisional wound debridement</td>
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<td><strong>Fourth quarter 2000</strong></td>
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<td>➤ How to report escharotomy</td>
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<td><strong>Third quarter 1991</strong></td>
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<tr>
<td>➤ Guidelines for coding excisional versus nonexcisional debridement</td>
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<tr>
<td><strong>Fourth quarter 1988</strong></td>
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<tr>
<td>➤ Revised code assignment to differentiate between excisional and nonexcisional debridement</td>
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FIs and Medicare administrative contractors have reviewed and verified. CMS also released final FY 2010 and preliminary FY 2011 labor market hourly wage data. Hospitals that want to correct errors in any public use files released in February must do so no later than March 8. Requests also must include any supporting documentation for the correction.

**EHR incentive update**


IPPS hospitals that have a qualified EHR and meet the meaningful use criteria are eligible to receive the incentives. A CMS official said that incentive regulations will become effective October 1 and that incentive payments should follow shortly thereafter. Providers may comment on the proposed regulations for 60 days or until March 13.

**Observation services**

A CMS official provided follow-up information regarding a question from a previous ODF. The question pertained to a hospital’s notification requirements when a patient who doesn’t meet inpatient criteria wants to remain in the hospital after the end of observation services.

The official said the limitation on liability provision specifies that a hospital must provide an advance beneficiary notice (ABN) when it wants to charge a patient who doesn’t meet inpatient criteria for using hospital resources after observation services have ended. Any services rendered after observation has ended are considered custodial, and CMS will not pay for them.

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Another caller commented that many beneficiaries don’t understand the ABN form, nor do they understand the nuances that differentiate inpatient and observation status. The caller said many patients simply select option three, which indicates they don’t want to receive services and that they are not responsible for payment. However, even after selecting this option, many patients continue to stay in the hospital and use resources, she added.

A CMS official said hospitals have an obligation to explain the ABN form to beneficiaries. When patients no longer need hospital care, they become liable for payment for services rendered during the continued stay. Another official said the agency understands the difficulty of explaining this complex information to beneficiaries who may not understand the intricacies of the Medicare system. He noted that CMS continually solicits feedback to try to improve its communications.

The CMS official referred the caller to a pamphlet the agency published to help educate patients about inpatient and observation care. Access the document, entitled Are You a Hospital Inpatient or Outpatient? If You Have Medicare, Ask! at www.medicare.gov/Publications/Pubs/pdf/11435.pdf.

Inpatient discharge prior to room assignment

A CMS official provided follow-up information regarding another question from a previous ODF. The question pertained to billing for situations in which patients are admitted to the hospital but leave before they are assigned a room and presumably against medical advice.

The official cited the following reference as excerpted from the Medicare Claims Processing Manual, 100.4, Chapter 3, 40.2.2, Section K:

   A patient of an acute care hospital is considered an inpatient upon issuance of written doctor’s orders to that effect. If a patient either dies or is discharged prior to being assigned and/or occupying a room, a hospital may enter an appropriate room and board charge on the claim. If a patient leaves of their own volition prior to being assigned and/or occupying a room, a hospital may enter an appropriate room and board charge on the claim as well as a patient status code 07 which indicates they left against medical advice. A hospital is not required to enter a room and board charge, but failure to do so may have a minimal impact on future DRG weight calculations.

Three-day payment window

During the Q&A, a caller requested clarification regarding the three-day payment window. She said her FI uses ICD-9 codes and clinical data to determine whether outpatient diagnostic services are related to inpatient admissions that occur within the three-day window. She asked whether FIs may look beyond the ICD-9 codes.

A CMS official responded that the agency’s policy with respect to this matter has remained unchanged for at least 12 years despite how often callers ask this question during ODFs. He reiterated that all diagnostic services provided three calendar days before the calendar day on which the patient is admitted are bundled and paid as part of the inpatient stay. When therapeutic services are provided during the three-day window—and those services are related to the inpatient stay based on an ICD-9 code match—CMS will bundle them as well.

Condition code 44

During the Q&A, another caller asked whether a nonphysician practitioner may concur with the utilization review (UR) committee’s decision to change a patient’s status from inpatient to outpatient.

A CMS official said that condition code 44 policy requires physician concurrence with a UR committee determination. The physician providing the concurrence may be a member of the UR committee; however, the physician cannot also provide the ultimate committee determination. A different physician must fill this role. The State Operations Manual states that under no circumstances may a nonphysician practitioner make a final determination about a beneficiary’s admission or continued stay. Refer to the Conditions of Participation, section 482.30(d) (1), for more information. ■
**Don’t rely solely on an encoder**

*Question clinical details when reporting chronic and acute heart and renal disease*

by Robert S. Gold, MD

Despite the evolution of codes for chronic and acute heart and renal disease over the past 20 years, the sequencing guidelines that address these conditions unfortunately remained unchanged. The result is that coders may assign principal diagnoses that may misrepresent a patient’s true clinical picture. Encoders contribute to this problem.

Coders must first understand that chronic heart disease and chronic kidney disease are caused by a particular underlying condition or the cumulative effect of several underlying conditions. Similarly, acute heart disease and acute kidney disease also are caused by an underlying condition. However, the same underlying condition doesn’t typically cause both the chronic version of the diseases and the acute diseases.

Hypertension and renal disease traditionally have been linked together because, in the past, hypertension was the most frequent cause of renal disease. Today, however, diabetes is the most common cause of renal disease, according to the American Diabetes Association. Although the connection between hypertension and renal disease still exists, hypertension should really link only to chronic renal disease—not the acute form of the condition.

**Question the encoder’s accuracy**

The problem is that encoders typically prompt coders to assign a code for hypertension or diabetes when the patient has acute renal failure. Coders also may be prompted to change the code from the 403 series or the 250 series when the patient has either hypertension or diabetes and acute renal failure. Both prompts are incorrect. Although the patient may have a chronic background condition of hypertensive nephrosclerosis or diabetic glomerulosclerosis, the acute renal failure is acute—not chronic. Acute renal failure almost always has absolutely nothing to do with a patient’s hypertensive state. The only exception to this is a hypertensive emergency, which can have a direct causative effect on acute renal failure.

Coders must report codes that accurately capture the clinical picture as specifically as possible. This includes reporting a code for the acute renal failure, the acute decompensation of renal function, and a code for the cause of the decompensation (e.g., dehydration, rhabdomyolysis, sepsis, bladder outlet obstruction). When the patient has a known level of chronic hypertensive renal disease, report 403.xx and the known level of chronic kidney disease (585.x). Reporting 403.x1 alone is not sufficient to express acute renal failure in a patient with chronic hypertensive renal disease.

To report the code for hypertensive heart disease, a physician must link the hypertension and heart disease. The National Centers for Health Statistics even changed the definitions of the codes for hypertensive heart disease (402.xx) from “with congestive heart failure” to “with heart failure,” implying the chronic state and not the acute state of the disease.

However, acute heart failure can occur when a patient also has hypertensive heart disease regardless of whether the patient has a history of heart failure.

Regardless of the scenario, codes reported should reflect clinical details. For example, a patient may develop acute diastolic heart failure from atrial fibrillation with rapid ventricular response. If the patient also has background hypertensive heart disease with chronic systolic or chronic diastolic dysfunction as the cause, the dysfunction must be coded separately. This patient does not have acute on chronic heart failure. The principal diagnosis would not be hypertensive heart disease with heart failure because the cause of the acute decompensation has nothing to do with the hypertension.

> continued on p. 12
Clinically speaking  < continued from p. 11

_Coding Clinic_ specifies that coders must report the acute code (428.xx) with a fifth digit of 1 as principal. When the patient also has chronic heart failure, report the acute on chronic code with a fifth digit of 3. When the physician documents congestive heart failure, assign 428.0. For hypertensive heart disease without heart failure, report 402.90 as well as the cause of the acute decompensation (i.e., the arrhythmia).

Diabetic or hypertensive renal disease is a chronic background condition. When a patient develops acute renal failure, it is almost never due to the diabetes or the hypertension. It’s usually due to some other cause.

A patient without hypertension or diabetes can develop acute renal failure or acute congestive heart failure. This is not hypertensive or diabetic renal disease, nor is it hypertensive heart disease. A patient with hypertension or diabetes can develop acute renal failure or acute heart failure that is totally unrelated to the hypertension or diabetes. Again, this is not hypertensive or diabetic renal disease, nor is it hypertensive heart disease.

Two recent experiences prompted this discussion:

➤ A patient was admitted with acute renal failure, and a coder was prompted to report “with manifestations of diabetes.” Although the patient was indeed a diabetic with known mild diabetic renal disease, the coder reported a code from the 250 series to denote the principal diagnosis. The acute renal failure was due to severe dehydration from fluid losses from the gastrointestinal tract for which the patient was treated. The patient’s chronic diabetic state did not suddenly change; however, the coder coded the scenario as though it had changed. This is wrong.

➤ In the second case, a patient was admitted with acute heart failure due to decompensation due to dietary indiscretion. The physician documented hypertensive heart disease and valvular heart disease. A coder was prompted to answer a series of questions in the encoder that resulted in assignment of a code from the 402 series to denote the principal diagnosis. Why is this wrong? The patient’s hypertension had nothing to do with the patient’s decompensation.

_Editor’s note: Dr. Gold is CEO of DCBA, Inc., a consulting firm in Atlanta that provides physician-to-physician programs in clinical documentation improvement. Reach him by phone at 770/216-9691 or by e-mail at DCBAInc@cs.com._

**Correction**

In last month’s column, we incorrectly stated that coders should report 428.9 for valvular cardiomyopathy. Instead, report 425.9.
We want your coding and compliance questions!
The mission of Coding Q&A is to help you find answers to your urgent coding/compliance questions.
To submit your questions, contact Briefings on Coding Compliance Strategies
Contributing Editor Lisa Eramo at leramo@hotmail.com.

A recent audit at our facility revealed that inpatient coders were reporting codes for accidental puncture or laceration during a procedure (ICD-9-CM code 998.2) and the dissection of a coronary artery during surgery (ICD-9-CM code 414.12).

Auditors said that 1994 Coding Clinic guidance and the ICD-9-CM Manual indicate that no “code also” guidance exists for code 998.2. Therefore, our coders have mistakenly been adding code 414.12, resulting in an $8,000 error because code 414.12 is an MCC.

Our organization has asked us to reach out to other resources to validate the auditors’ findings. Our HIM director and coding manager have made it clear that we must abide by the auditors’ findings that ICD-9-CM code 414.12 is an extra code that we should not report to identify a complication of the surgery. However, I would like to hear from others in the coding community.

The ICD-9-CM Coding Guidelines, Chapter 17: Injury and Poisoning (800–999), include no specific guidelines. However, the guidelines in Section 1, Part B, Item 9 of the ICD-9-CM Manual state, “Multiple codes may be needed for late effects, complication codes, and obstetric codes to more fully describe a condition.”

I interpret this to mean that including both of these codes to tell the whole story is the proper way to report a patient suffering from a dissected coronary artery caused by a procedural accident. This would also support medical necessity for treatment of the dissection more specifically than submission of a claim without code 414.12.

I want to stress the importance of following specific guidelines rather than letting the $8,000 figure affect how you report this condition. We all know that changing coding methodology to directly affect payment is fraud.

Try referencing the following Coding Clinic issues:
➤ 2007, second quarter, p. 9
➤ 2006, first quarter, p. 15
➤ 2002, third quarter, pp. 24 and 26

These references address ICD-9-CM code 998.2, and they are more recent than the 1994 citation the auditor provided.

Shelley C. Safian, MAOM/HSM, CCS-P, CPC-H, CHA, of Safian Communications Services in Orlando, FL, answered the previous question.

Which code(s) should I report for “exposure to flu without symptoms”? Should I report V01.79, V01.89, or both?
No ICD-9-CM code denotes “exposure to flu without symptoms.” Therefore, report both codes referenced in your question—V01.79 (other viral disease) and V01.89 (other communicable disease).

How should I code capillary leak syndrome secondary to biochemotherapy? Can you provide coding guidelines or a rationale for your answer?

> continued on p. 2
Systemic capillary leak syndrome is difficult to diagnose, although it does typically have the following classic symptoms:

➤ Nasal congestion
➤ Runny nose
➤ Cough

However, it’s important to note that each of these symptoms can be mistaken for an upper respiratory viral infection.

Mayo Clinic provides helpful information about capillary leak syndrome. To learn more, visit www.mayoclinic.org/systemic-capillary-leak-syndrome/diagnosis.html.

ICD-9-CM does not include a code for this syndrome, nor does Coding Clinic address how to code the condition. Therefore, coders must report it as a capillary disease with the unspecified code 448.9 (other and unspecified capillary diseases).

Coders also should report E933.1 (adverse effect of antineoplastic and immunosuppressive drugs). The ICD-9-CM Official Guidelines for Coding and Reporting that became effective October 1, 2009, state in pertinent part that:

Codes from the E930–E949 series must be used to identify the causative substance for an adverse effect of drug, medicinal, and biological substances, correctly prescribed and properly administered. The effect, such as tachycardia, delirium, gastrointestinal hemorrhaging, vomiting, hypokalemia, hepatitis, renal failure, or respiratory failure, is coded and followed by the appropriate code from the E930–E949 series.

In this case, the biochemotherapy caused the systemic capillary leak. Thus, coders should report E933.1.

If the patient exhibits other symptoms, assign codes for them as well. For example, when a patient presents with malaise, report 780.79. When a patient presents with nausea, report 780.02. When a patient presents with lightheadedness, report 780.4. Report each of these codes in addition to 448.9.

What code should I report for Delleman syndrome?

Delleman syndrome—otherwise known as oculocerebrocutaneous syndrome—is a rare sporadic birth condition characterized by the following conditions:

➤ Orbital cysts
➤ Microphthalmia and anopthalmia
➤ Focal skin hypoplasia
➤ Skin tags
➤ Cerebral malformations

ICD-9-CM does not include a specific code for this syndrome. However, Coding Clinic, first quarter 1994, pp. 8–13, states that coders should assign an appropriate code from categories 740–759 (congenital anomalies) when a specific abnormality is diagnosed for an infant. Such abnormalities may occur as a set of symptoms or multiple malformations. Assign a code for each presenting manifestation of the syndrome if the syndrome is not specifically indexed in ICD-9-CM.

Therefore, assign 759.7 (multiple congenital anomalies). If the infant has any of the above conditions, assign codes for the conditions as well. For example, report 376.81 for orbital cyst, 743.10 for microphthalmia, 757.39 for focal skin hypoplasia and/or skin tags, and 747.81 for cerebral malformation (anomaly).

Sandra Sillman, RHIT, PAHM, DRG coordinator at Henry Ford Health System in Detroit, answered the previous three questions.