Ask ACDIS

Query appropriately for fluid overload vs. CHF

A provider documents “fluid overload” as a separate diagnosis but also documents chronic diastolic CHF. The chest x-ray shows "mild CHF." The medical record further shows that the patient’s pro-BNP (B-type natriuretic peptide) is slightly elevated at over 200 and the patient is being diuresed with Lasix®.

According to Coding Clinic, second quarter 2001, p. 13: "Fluid overload due to noncompliance," and Coding Clinic, third quarter 1996, "Fluid overload is a component of congestive heart failure and should not be coded separately."

With the background documentation above, is it appropriate to prompt the physician for the acute condition of CHF (i.e., acute on chronic diastolic CHF)? From a physician standpoint, is this acute on chronic CHF? I realize the patient must have documented symptoms of CHF.

This is a classic documentation opportunity to clarify "volume/fluid overload," says Lynne Spryszak, RN, CPC-A, CCDS, CDI education director for HCPro, Inc., in Danvers, MA.

“If the physician hasn’t documented acute CHF, I would hesitate to ask for this condition based on this mild BNP elevation,” Spryszak says.

Instead, review the record for the following clinical indicators/additional information to support the diagnosis:

» An echocardiogram report
» Home (and continuing) CHF medications (e.g., ACE inhibitors, beta blockers, ARBs, along with the Lasix).
» Cardiology consult

While the fluid overload may be related to the documented chronic diastolic heart failure, the physician should establish any potential linkage in the documentation.

Consider the following sample query/clarification:

Dear Dr. Smith, noted CXR showing “mild CHF” and orders to administer Lasix. The documentation states “fluid overload” as well as “chronic diastolic heart failure.” Without specific documentation, a cause-and-effect relationship may not be assumed. In your next progress notes and discharge summary, please clarify the etiology of the fluid overload:

» Fluid overload due to chronic diastolic CHF
» Fluid overload due to acute on chronic diastolic CHF
» Fluid overload due to other (please state): __________________
» Fluid overload not clinically significant
» Etiology of fluid overload undetermined
» Other (please state): __________________

However, the situation described in the above scenario is probably more complex than it seems, says Robert S. Gold, MD, president of DCBA, Inc., in Atlanta. In the scenario, it appears that the radiologist documented “mild CHF,” which should not happen since only the treating physician can provide a diagnosis for his or her patient.

“The information provided does not tell us if the patient’s medications were altered significantly (such as 60 mg Lasix IV push) when it was found that the BNP was 200,” says Gold.

Furthermore, a patient may have a BNP in the 200–500 range with no acute conditions if he or she suffers from chronic renal disease or a severely dilated heart, although this patient clearly does not have either of these conditions, Gold says.

A CDI specialist should seek further clarification regarding the patient’s chief complaint that occasioned his or her visit to the facility, Gold says, noting that any query to the physician should be based on the patient’s presenting complaints and a complete review of the medical record. When reviewing the record in a case such as this, the CDI specialist should ask what caused the fluid overload, if it is an ESRD patient, or whether the patient forgot to take his or her hypertension medication.

“All in all,” says Gold, “we need more information to offer more solid advice. The fluid overload is caused by something, and it’s not caused by heart failure, either acute or chronic. Fluid overload can put a patient with chronic heart failure into acute heart failure, for sure, but we have no evidence of that, either.”

Editor’s note: Contact Gold at DCBAInc@cs.com or Spryszak at Ispryszak@cdiaassociation.com.

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