ICD-10

Continue preparations despite proposed delay

CMS has proposed delaying ICD-10 implementation until October 1, 2014, but coders shouldn’t delay their preparations for the new code system, experts say.

“Coders should take this extra year to continue brushing up on their anatomy and physiology, medical terminology, and pathophysiology skills,” says Melanie Endicott, MBA/HCM, RHIA, CCS, CCS-P, director of professional practice at AHIMA in Chicago. “They can also continue to become familiar with the ICD-10-CM and ICD-10-PCS Official Guidelines for Coding and Reporting, as well as learn the basics about assigning these new code sets, such as format and structure.”

Coders who undergo ICD-10 training can assist with other aspects of ICD-10 readiness, says Gloryanne Bryant, RHIA, CCS, CDIP, CCDS, an AHIMA-approved ICD-10-CM/PCS trainer in northern California with more than 30 years of HIM experience.

Coders with formal ICD-10 training can review and update query forms or work with CDI staff to create new queries that reflect ICD-10 terminology and indexing. Trained coders can inventory policies and procedures that will require review and updating, she says.

“Use your ICD-10-trained staff to assist with MS-DRG financial modeling efforts as well. All of these activities and tasks take time and effort,” says Bryant. ICD-10-trained staff can conduct productivity studies to determine the impact the new coding system will have on their organizations, she says.

A delay equals additional costs, and a one-year delay could add an estimated 10%–30% to the total implementation cost for entities that have already spent or budgeted for the transition, according to the proposed rule.

The proposed one-year delay will increase costs because organizations must stretch their implementation preparation another year and try to maintain momentum, says Endicott.

The good news is that if CMS finalizes the 2014 compliance deadline, it’s not likely that it will change again, says Sue Bowman, MJ, RHIA, CCS, senior director of coding policy and compliance at AHIMA in Chicago.

“CMS is aware of the importance of a firm date for this type of implementation,” she says. “The healthcare industry has been engaged in various aspects of ICD-10 implementation for nearly 20 years now, so it is time to finish the process so that we can start to reap the benefits of ICD-10, stop increasing the implementation costs, and move on to other important initiatives.”

Editor’s note: Access the proposed rule, published in the April 17 Federal Register, at http://tinyurl.com/cl6brmn.
MAC prepayment reviews hit hospitals hard

MACs have already begun prepayment reviews at hospitals nationwide, and Medicare Recovery Auditors aren’t far behind.

MAC prepayment reviews denote a stark contrast from CMS’ previous pay-and-chase methodology, says Monica Lenahan, CCS, coding education and compliance manager at Centura Health in Englewood, Colo. “It’s a whole new ball game for us,” she says.

TrailBlazer Health Enterprises, LLC (TrailBlazer), began auditing the 13-hospital health system in October 2011. The MAC issued 300 requests systemwide in the first month alone, and that volume has continued to grow, says Lenahan.

Other hospitals are experiencing similar headaches.

“We’re getting hit hard by [MAC prepayment audits] at this time,” says Paul Belton, RHIA, MHA, MBA, JD, LLM, vice president of corporate compliance at Sharp HealthCare, an integrated seven-hospital healthcare system in southern California. Since Palmetto GBA began requesting records in October 2011, the MAC has audited several hundred requests throughout the system, he says.

“For the first time ever, this is impacting our cash flow,” says Belton. “We’re seeing a tremendous amount of activity on the same DRGs that the Recovery Auditor has historically focused on.” This includes pneumonia, chronic obstructive pulmonary disease, and heart failure and shock. The major difference is that MACs are reviewing claims before they’re paid, he says.

Belton fears the Recovery Auditor prepayment demonstration program will mirror the MAC process with respect to volume. California is among the states included in the Recovery Auditor demonstration program slated to begin in June.

Neither rhyme nor reason seems apparent

One puzzling aspect of Centura Health’s MAC prepayment reviews is the inconsistency with respect to the type or volume of DRGs reviewed at each of the system’s 13 hospitals, says Lenahan.

Belton reports a similar experience, noting that one of the anchor hospitals in the Sharp HealthCare system received a very disproportionate share of requests—approximately 70%—during the first six months of the program.

MACs are targeting services and items that “pose the greatest financial risk to the Medicare program and that represent the best investment of resources,” according to the Medicare Program Integrity Manual, Chapter 3—Verifying Potential Errors and Taking Corrective Actions. This includes services with significant potential for noncovered or incorrect coding. CMS encourages MACs to use prepayment and post-payment screening tools or natural language coding software to identify these targets.
MAC prepayment audits have prompted Centura Health to examine high-dollar DRGs (e.g., those for joint replacements) and high-volume DRGs (e.g., DRG 392 [gastroenteritis and miscellaneous digestive disorders without MCC]) more closely, says Lenahan.

Sharp HealthCare has been placing greater emphasis on medical necessity and determining whether documentation in the medical record tells a patient’s entire story to support outpatient services and inpatient admission, says Belton. HIM staff members ask these two questions when reviewing documentation prior to releasing claims:

➤ Is there an accurate physician status order?
➤ Does the physician demonstrate his or her complex medical judgment by documenting the patient’s current symptomatology, past medical history, CC conditions, and ancillary studies with interpretation?

“All of this reinforces the fact that case management must work with HIM more than ever before,” he says.

Sharp HealthCare will provide CDI education to physicians to prepare for MAC prepayment reviews and Recovery Auditor prepayment reviews, says Belton. Education will proactively target hospitalists, intensivists, and ER physicians.

Understand the process

So how do MAC prepayment reviews actually work?

Hospitals must respond to Additional Documentation Requests (ADR) for MAC prepayment reviews within 30 days of receiving a request from a MAC. If a MAC doesn’t receive this documentation within 45 days, it will automatically deny the claim. If a MAC receives documentation in a timely manner, it must make and document its determination within 60 calendar days. It must also enter its payment decision into the Fiscal Intermediary Shared System, Multi-Carrier System, or the VIPS Medicare System within this same time frame.

Lenahan hasn’t yet tracked the average time it has taken TrailBlazer to make prepayment determinations. However, Centura Health is tracking the money it would have received had prepayment reviews not been triggered. The dollar amount is significant, says Lenahan. “It really is a huge payment burden,” she says.

Identify operational challenges

In addition to cash flow disruption, MAC prepayment reviews have also caused operational challenges. Centura Health created a flag in its billing system to identify claims selected for prepayment review.

Logging these claims internally has been challenging, says Lenahan. Currently, a billing manager performs this function. However, ADRs are sometimes sent directly to facilities rather than a centralized billing office, which makes logging and tracking requests difficult. Lenahan hopes the hospital’s Recovery Auditor tracking software eventually will be able to track MAC prepayment requests as well.

Belton agrees that operational challenges exist. Sharp HealthCare’s Recovery Auditor/MAC coordinator tracks all requests systemwide. The coordinator logs each
request and sends the request to the medical records department at the hospital to which the request pertains. Requests are monitored based on the following reason codes provided by the MAC:

- Denied (MAC conducted a prepayment review and denied the claim)
- Paid (MAC conducted a prepayment review and agreed to pay the claim)
- Pending (MAC prepayment review is pending)
- Withdrawn (MAC is in the process of reviewing the claim, payment is pending, but the review is taking longer than anticipated)

When claims are denied, the Recovery Auditor/MAC coordinator sends records to a case manager at each hospital to determine whether the hospital can appeal the denial. Approximately 20% of the claims reviewed during the first six months were denied immediately upon prepayment review, says Belton. Approximately 75% of the claims reviewed during the first six months had a “withdrawn” status at some point during their review.

TrailBlazer notifies Centura Health of its payment decision via a reason code as well (e.g., no payment is forthcoming), says Lenahan.

**Encourage physician involvement**

Physicians at Centura Health have become more involved in documentation improvement efforts since the onset of MAC prepayment audits, says Lenahan. This is because TrailBlazer reviews Part A hospital claims as well as Part B claims for services rendered in place of service 21 (inpatient hospital). The MAC looks specifically at the history and physical completed by the surgeon, operative reports, imaging reports, and any other pertinent information in the record on Part A claims, says Lenahan. The MAC examines Part B claims for the same dates of service as hospital claims to search for this information as well.

When Part A hospital claims are denied, TrailBlazer has also denied the Part B physician claim, Lenahan says. “Now it affects physicians’ bottom line, and they’re very interested in this,” she says. “If we’re getting a payment denial, they’re getting one right behind it.”

Centura Health has made a concerted effort to include details from physician documentation in documentation submitted with hospital claims, says Lenahan. For example, although hospital documentation must satisfy Joint Commission requirements and inpatient admission criteria, staff members also ensure that it includes elements of physician documentation specified by TrailBlazer (e.g., a physician’s description of the failure of outpatient therapy). The health system is in the process of designating someone (e.g., intake clerk, scheduling clerk, or medical records staff member) to ensure this information is included.

“There may be lots of documentation in the physician record that would help us substantiate these procedures,” Lenahan says. “We’re establishing a checklist at the beginning of the process to ensure that we have everything we need because we’re pretty sure this will be challenged on the back end. That’s something we’ve never done before.”

**Good news going forward**

CMS recognizes that direct communication between MACs and providers is an essential part of solving compliance problems going forward. The *Medicare Program Integrity Manual* requires that MACs include “an offer to provide individualized education in the notification letter along with contact information for provider outreach and education.”

**Resources**

Consider these resources:

- *Medicare Program Integrity Manual*, Chapter 3—Verifying Potential Errors and Taking Corrective Actions:
  [http://tinyurl.com/7ux7qmu](http://tinyurl.com/7ux7qmu)
- TrailBlazer joint replacement documentation:
  [http://tinyurl.com/7xn4jg](http://tinyurl.com/7xn4jg)
- TrailBlazer documentation tips: [http://tinyurl.com/7m2po55](http://tinyurl.com/7m2po55)
Many physicians say that SIRS criteria are insufficient and confusing at best, and don’t indicate whether a patient is truly sick, says Robert S. Gold, MD, founder and CEO of DCBA, Inc., in Atlanta.

Some patients—particularly those who are critically ill—may meet necessary criteria for SIRS and truly have sepsis or another severe diagnosis. Others, however, may meet two of four criteria (e.g., heart rate > 90 and respiratory rate > 20)—which technically constitutes a diagnosis—but not have SIRS.

“Abnormalities in vital signs and abnormalities in laboratory studies can be due to things that are totally unrelated to a patient’s infectious process in the body or can be present totally unrelated to an inflammatory process in the body,” says Gold. “If there is no inflammatory process, docs should not call it SIRS because you must have an inflammatory process to get a systemic inflammatory response.”

For example, tachycardia with atrial fibrillation and rapid ventricular rate doesn’t justify a SIRS diagnosis, says Gold. If a patient has leukocytosis with injection of steroids, this also doesn’t imply SIRS. Similarly, tachypnea with tachycardia caused by running does not meet SIRS criteria, he says.

To confuse matters, some patients—particularly those who are immunocompromised—may have sepsis without meeting any criteria, says Gold. “You have to look at the possibility that a patient can be septic and indeed be in septic shock and not have the SIRS criteria met at all,” he says. “It’s a clinical judgment of the physician in looking at the patient to be able to determine if the patient has a risky infectious process or a risky noninfectious process.”

Bridge coder-physician communication gap

So where does all of this information leave coders? Often, between a rock and hard place, says Jennifer E. Avery, CCS, CPC-H, CPC, CPC-I, senior regulatory specialist at HCPro, Inc., in Danvers, Mass. Physicians don’t diagnose—or document—consistently, which often leads to inaccurate data capture, she says. Many coders are uneasy coding records in which physicians mention sepsis or SIRS only once or twice without documenting any clear clinical evidence or treatment. They hesitate to code the condition because they know the claim may be denied, she says.

Coders should take time to more thoroughly review and learn from these records rather than be overwhelmed by them, says Avery.

“Coders have never had to be as clinical as we’re challenged to be now,” she says. “Coders have the ability to gain some of the pathophysiology knowledge to read the record and be able to abstract what’s important.”

As with all documentation challenges, it’s always best to emphasize to physicians the importance of capturing patient severity. This includes the following elements related to sepsis and SIRS:

➤ The inflammatory condition, whether infectious or noninfectious
➤ The causal organism
➤ Whether a noninfectious process is contributing to a patient’s illness and the specific process

When in doubt, coders should query even though it may seem as if they are questioning physicians’ clinical judgment, says Avery.

“I don’t think it’s really that we’re questioning their judgment per se, I think it’s more that we’re questioning the accuracy of the record,” she says. “If the condition is not clearly documented, then we shouldn’t be picking it up.”

Effective strategies for coding sepsis

Coders should review documentation more thoroughly, query when necessary, and consider the following seven coding tips:

1. Note differences between streptococcal sepsis and streptococcal septicemia. When physicians
document streptococcal septicemia, coders should report code 038.0 (streptococcal septicemia) only. They should not report code 995.9x (SIRS) as an additional code. Coders also should query physicians to determine whether a patient actually has sepsis instead, in accordance with official coding guidelines.

Nonetheless, query with caution, says Avery. “I think we over-query in this area for a condition that’s really not there,” she says. “I think a lot of physicians over time have become desensitized to it.”

Coders should review clinical evidence in the record before querying physicians, she says. They should also be careful when referencing SIRS criteria to avoid backing physicians into a corner to provide diagnoses that may technically satisfy diagnostic criteria without actually being present, she says.

Conversely, if physicians document streptococcal sepsis, coders should report codes 038.0 and 995.91 (SIRS due to infectious process without acute organ dysfunction).

2. Look for linkage between organ dysfunction/failure and severe sepsis. Severe sepsis (995.92) occurs when sepsis is accompanied by signs of failure of at least one organ. Documentation of all organ dysfunctions and failures—including any related treatments (e.g., tracheostomy)—is important with respect to supporting the overall diagnosis, says Avery.

However, an acute organ dysfunction must be associated with the sepsis to assign the severe sepsis code, she says.

“Just because a physician identifies a patient has acute respiratory failure or acute renal failure [doesn’t mean] that you can jump to a conclusion that it’s sepsis,” Avery says. Coders should query physicians when documentation is unclear regarding whether acute organ dysfunction is related to sepsis or another medical condition, she says.

3. Know how to apply sequencing guidelines.

“It’s really clear if a patient comes in with some type of localized infection and then develops sepsis while they’re in the hospital,” says Avery.

However, sequencing isn’t as clear when patients appear to be admitted for sepsis, organ failure, localized infection, or something else, she says. Consider the following suggestions:

– Sepsis or severe sepsis is POA and meets the definition of a principal diagnosis—Assign a code for the systemic infection (e.g., 038.xx or 112.5 [disseminated or systemic candidiasis]) first, followed by 995.91 or 995.92.

– The reason for admission is sepsis, severe sepsis, or SIRS and a localized infection (e.g., pneumonia or cellulitis)—Assign a code for the systemic infection (e.g., 038.xx or 112.5) first, followed by 995.91 or 995.92, and then a code for the localized infection. Refer to Coding Clinic, Third Quarter 2011, for an example that illustrates this guideline.

– A patient is admitted with a localized infection (e.g., pneumonia), but sepsis or SIRS doesn’t develop until after admission—Assign a code for the localized infection as the principal diagnosis. Also assign a code for the systemic infection (e.g., 038.xx or 112.5) and code 995.91 or 995.92 as secondary diagnoses.

– Sepsis or severe sepsis is not POA but develops during the encounter—Assign a code for the systemic infection and code 995.9x both as secondary diagnoses. Remember that when signs or symptoms of sepsis are POA but physicians don’t document the condition until after admission, the record may justify a query to determine whether sepsis was POA. Official coding guidelines instruct coders to assign “Y” for conditions diagnosed during an admission that were clearly present but not diagnosed until after admission occurred.
4. **Wait for the discharge summary.** If a physician documents a diagnosis as probable, suspected, likely, questionable, possible, or still to be ruled out at the time of discharge, coders can report the condition as if it existed or was established. Physicians might document possible sepsis or probable sepsis in the record. If the condition is also documented in the discharge summary, coders can report it as if it existed, says Avery. If it’s not included in the discharge summary, clinical evidence in the record might justify a query and possibly confirm the diagnosis, she says.

5. **Note unique aspects of coding newborn sepsis.** When a physician documents newborn sepsis, coders should report code 771.81 (septicemia [sepsis] of newborn) with a secondary code from category 041.x (bacterial infection in conditions classified elsewhere and of unspecified site) to identify the organism. Coders shouldn’t report a code from category 038, nor should they assign code 995.91, says Avery. Conversely, if a newborn has any associated acute organ dysfunction, report 995.92.

   Remember that the 770 code series is reserved for conditions that follow the birth process and are directly related to it. These conditions must occur within the first 28 days of life. For example, coders should report 038.x when a baby develops sepsis from bacterial superinfection of a viral pneumonia caused by his 2-year-old sibling.

6. **Encourage physicians to stop documenting urosepsis.** This vague term currently maps to code 599.0 (UTI, site not specified) in ICD-9-CM. However, in ICD-10-CM, urosepsis is not a codeable term. The Alphabetic Index instructs coders to “code to the condition,” and it doesn’t provide a default code. Start encouraging physicians to document greater specificity now, says Avery.

7. **Don’t make assumptions when coding post-procedural sepsis.** “You cannot make an assumption that just because the patient has some type of post-procedure infection that develops into sepsis that the two [i.e., the procedure and sepsis] are related,” says Avery. “Physicians must clearly document the cause-and-effect relationship.”

   If a localized infection is post-procedural and related to an operation, assign a code for the complication (e.g., 998.59, other postoperative infection, or 674.3, other complications of obstetrical surgical wounds) first, followed by the appropriate sepsis codes (i.e., 995.91 or 995.92). Report additional codes for any acute organ dysfunction or failure in cases of severe sepsis. Refer to Coding Clinic, Fourth Quarter 2011, pp. 151–153 for more information.

   Editor’s note: This information was originally presented during HCPro’s audio conference “Sepsis Coding: Learn Documentation Improvement Techniques to Ensure Accurate Coding.” For details, visit http://tinyurl.com/73h6eah.
**Inpatient wound care**

**Address medical necessity, coding challenges**

Medical necessity denials traditionally focus on high-dollar DRGs, such as those for hip and knee replacements; others may also soon become targets.

Inpatient wound care frequently lacks sufficient documentation and could be one such service, says Glenn Krauss, BBA, RHIA, CCS, CCS-P, CPUR, PCS, FCS, C-CDIS, CCDS, an independent HIM consultant in Madison, Wis.

“[Auditors] haven’t gotten there yet, but I suspect they will,” says Krauss. “Documentation lacks the clinical substance necessary to support medical necessity, and it doesn’t capture a physician’s clinical judgment and medical decision-making for performing the procedure. Doctors have been conditioned to document excisional debridement, but if you look at what they need for their own payment, they need to do a lot more than that.”

Outpatient wound care documentation is often more detailed and thorough than its inpatient counterpart because physicians providing these services often specialize in this area and are “more attuned to the business side,” Krauss says. Outpatient wound care center documentation often includes dictated notes, pictures, documentation of failed conservative treatment, wound etiology notes, and information about patient compliance and the stability and interaction of active comorbidities. Hospitals often can’t obtain this specificity, he says.

Local coverage determinations that focus on outpatient wound care documentation, such as that published by TrailBlazer Health Enterprises®, can be helpful on the inpatient side, he says. (Visit [www.trailblazerhealth.com/Tools/LCDs.aspx?id=2897](http://www.trailblazerhealth.com/Tools/LCDs.aspx?id=2897).)

“If we [used this information] on the inpatient side, everything would be golden,” says Krauss. Some hospitals use TrailBlazer’s information to develop inpatient wound care documentation templates for their physicians, he says. One copy is for the hospital; the other is the physician’s for billing purposes.

**Excisional or non-excisional?**


The newsletter describes excisional debridement as the surgical removal or cutting away of devitalized tissue, necrosis, or slough. It notes that coders incorrectly report excisional debridement when physicians perform autolytic, enzymatic, or mechanical (whirlpool) debridement. Instead, they should report non-excisional debridement of wound, infection, or burn (86.28). Recovery Auditors have performed validation for these MS-DRGs:

- 463–465 (Wound debridement and skin graft except hand, for musculo-connective tissue disorders with MCC/CC, with CC, and without CC/MCC respectively)
- 573–575 (Skin graft and/or debridement for skin ulcer or cellulitis with MCC, with CC, and without CC/MCC respectively)
- 901–903 (Wound debridements for injuries with MCC, with CC, and without CC/MCC respectively)

Unfortunately, the terms *excisional* and *non-excisional* are specific to ICD-9-CM and may not be how physicians identify procedures, says Nelly Leon-Chisen, RHIA, director of coding and classification at the AHA in Chicago. Physicians must understand how ICD-9-CM terminology differs from their own clinical terminology, and also the risk of inaccurate coding, she says.

Coders, meanwhile, must realize that documentation of excisional debridement won’t necessarily survive payer scrutiny, says Krauss. “Just because the magic word is in the chart doesn’t mean that you’re going to get paid,” he says. “It’s not just about getting the buzzword—it’s about getting the support for the buzzword.”

Documentation of indications for a procedure (i.e., why debridement was necessary) is often lacking, says
Krauss. When combined with a brief progress note indicating excisional debridement without complications, it can appear that services may not have been medically necessary. Payers seek documentation of clinical progression, advancement of wounds, and failure of previous conservative therapy as a primary basis for establishing medical necessity of debridements, he says.

Debridement of multiple layers

*Medicare Quarterly Provider Compliance Newsletter*, October 2011, Vol. 2, Issue 1, reminds coders to assign a code only for the deepest layer of debridement when coding multiple-layer debridements of the same site.

The newsletter scenario involves a debridement including skin, subcutaneous tissue, and muscle. Assign 83.45 (debridement of muscle, NOS)—not 86.22 (excisional debridement of wound, infection, or burn).

Debridement depth documentation challenges may continue, says Leon-Chisen. For example, “debridement down to the bone” could be interpreted as debridement stopped short of taking bone tissue or including the bone. Review documentation to determine the deepest layer debrided; seek clarification if necessary, she says.

The multiple-layer rule (i.e., code only the deepest layer debrided) applies solely to same-site debridement, says Krauss. Report debridement of separate sites independently and according to the deepest depth of the debridement performed at the specific site, he says.

Debridement with another procedure

Don’t code minor debridement to clean a bone or debridement that is part of a larger procedure separately, says Leon-Chisen. For example, debridement is integral to arthroscopic shoulder repair, she says.

Coders often err when reporting incision and drainage (I& D) performed with debridement, says Krauss. Don’t separately report debridement performed to ensure the effectiveness of I& D, but separately report debridement performed after I& D to address presence of significant necrotic tissue around an area that was incised and drained, he says. Documentation must clearly describe the necrotic tissue and procedure performed. *Coding Clinic, Second Quarter 2005*, pp. 3–4, notes that debridement performed with another procedure is often, but not always, included in the procedure code. Refer to *Coding Clinic, Third Quarter 2008*, p. 8; *Second Quarter 2006*, pp. 23–24; and *Second Quarter 1990*, p. 27.

The challenges of new technology

New technology can be challenging; coders might not know whether it can be classified as excisional, says Leon-Chisen. For example, when physicians use the Qoustic Wound Therapy System®, report 86.28, in accordance with *Coding Clinic*, Second Quarter 2010, pp. 11–12. When they use ultrasonic-assisted curette and VersaJet™, report 86.28, in accordance with *Coding Clinic*, Third Quarter 2009, p. 13.

Wound care and the POA indicator

Coders are often too cautious when assigning a POA indicator for pressure ulcers, especially when not documented until several days after inpatient admission, says Krauss. If signs or symptoms are POA, coders can and should report an ulcer as POA. A query may be necessary without documentation of signs or symptoms.

Educate ED clinicians about the importance of documenting chronic conditions (e.g., chronic heel wounds) in addition to acute conditions that prompt patients to seek treatment, says Krauss. This facilitates accurate POA assignment and reduces queries, he explains.

Prepare for ICD-10

ICD-10 distinguishes between excisional and non-excisional debridement. The ICD-10-PCS root operations excision and extraction denote excisional debridement and non-excisional debridement, respectively.

This doesn’t mean that physicians must use the term extraction, but if documentation shows that the tissue was pulled or stripped away, rather than cut, the debridement is an extraction, says Leon-Chisen.

ICD-10 will require coders to capture laterality and more specific anatomic wound locations, says Krauss.
Will acute respiratory failure be CC instead of MCC?

by Robert S. Gold, MD

Acute kidney injury or acute renal failure has up to a 78% mortality rate, yet it has been demoted from MCC to CC status. Why? Coders have overreported code 584.9 based on medical record documentation that patients have the condition when they don’t. I fear the same fate for the same reasons for code 518.8x (acute respiratory failure).

In some cases, it’s obvious that patients are in acute respiratory failure. In others, it may be less obvious and open to interpretation. In still others, patients are clearly not in acute respiratory failure.

A patient receiving oxygen or a mechanical ventilator isn’t necessarily in acute respiratory failure. Even physician documentation of acute respiratory failure doesn’t always validate acute respiratory failure. Someone must take a stand and repair the inaccurate data before acute respiratory failure is demoted to CC status and viewed as clinically insignificant.

Two well-known clinical models of respiratory failure currently exist:
➤ Type I, hypoxemic respiratory failure
➤ Type II, hypercapnic respiratory failure

Both types can exist in either the acute or chronic states. A patient can have one type exclusively or manifest elements of both types. Coders, however, have two choices: code 518.81 for acute respiratory failure and code 518.83 for chronic respiratory failure. These codes don’t reflect Type I or Type II, and there is no classification of either hypoxemic or hypercapnic types.

Hypoxemic respiratory failure
Type I (hypoxemic) respiratory failure, the most common form, occurs when a patient’s arterial partial pressure of oxygen (PaO₂) is lower than 60 while breathing room air and when there is a normal or low arterial partial pressure of carbon dioxide (PaCO₂). Type II (hypercapnic) occurs when a patient’s PaCO₂ is higher than 50. These indicators alone do not account for acuity.

Hypoxemic respiratory failure may be seen in patients with cardiogenic or noncardiogenic pulmonary edema, pneumonia, pulmonary embolism, or pulmonary fibrosis. It can also occur with lung toxicity due to certain antiarrhythmic drugs and pulmonary hemorrhage.

Hypercapnic respiratory failure

Type II (hypercapnic) respiratory failure often occurs in patients with severe chronic airway disorders (e.g., chronic asthma, COPD, neuromuscular diseases, cystic fibrosis). Hypoxemia is common in patients with hypercapnic respiratory failure who are breathing room air. Patients with hypercapnic respiratory failure often have an elevated carbon dioxide level in arterial blood gases (55–110 or higher instead of 35–45).

Acute and chronic types
The distinction between acute and chronic hypoxemic respiratory failure is not readily made on the basis of arterial blood gases. A patient with chronic hypoxemic respiratory failure may have a high hematocrit that shows polycythemia (i.e., increased red blood cell production to permit the transport of additional oxygen molecules to the body from the lungs), but this doesn’t always occur.

A physician who knows a patient may determine that the patient’s PaO₂ is 10%–15% lower than normal for this individual. If a patient’s oxygen saturation on pulse oximeter cannot be maintained over 90% on 6 liters flow of oxygen, physicians often interpret this as hypoxemic respiratory failure. If these levels are different from that which was recorded an hour earlier, the patient is in acute hypoxemic respiratory failure. If the levels remain the same hour after hour, day after day, it’s chronic.

Acute hypercapnic respiratory failure develops over
minutes to hours. The arterial pH, which is normally in the range of 7.35–7.45, is less than 7.3. Physicians may refer to this low pH and high PaCO₂ as “respiratory acidosis.” In chronic hypercapnic respiratory failure, the kidneys compensate for the acidity by increasing bicarbonate concentration. Therefore, the pH is usually only slightly decreased compared to the normal range.

Patients with acute respiratory failure often exhibit signs of anxiety—as if they fear imminent death. This often is seen in those with pulmonary embolisms. They may demonstrate an increased rate of breathing (more than 20–24 breaths per minute) and inability to speak more than a few words without stopping for another breath. They may exhibit use of accessory muscles of respiration as the neck and intercostal muscles retract, showing the increased muscular work to try to get the lungs moving. Eventually, patients experience cyanosis and loss of consciousness. A physician doesn’t need a blood gas determination to know the patient is tiring and requires intubation or other respiratory support.

So where do things go wrong if it’s all so clear?

Intubate for airway protection

Patients found unconscious after a stroke may be paralyzed, intubated, and placed on ventilators in case they vomit while unconscious and can’t respond to protect their airways. Patients who can’t respond will aspirate and possibly go into acute respiratory failure. However, if and until this happens, they are not in acute respiratory failure. Patients unconscious due to alcohol or drug use, but breathing, are not in acute respiratory failure. They may be paralyzed, intubated, and placed on a ventilator for airway protection, but they’re not in acute respiratory failure. Similarly, patients who have an allergic reaction with laryngeal edema may be intubated before the airway closes (if it’s going to close) for airway protection. They’re not in acute respiratory failure.

Recovery from anesthesia

Surgical patients are typically sent to the postanesthesia care unit (PACU) to recover from anesthesia. An anesthesiologist and PACU nurses monitor them until they are released to home, the medical-surgical unit, or the ICU. Often, these patients are totally reversed and extubated before leaving the OR. However, if an operative procedure lasts long or starts late, and the PACU is closed, the anesthesiologist may complete reversal of the patient the same night in the ICU. Nurses then monitor the patient and the anesthesiologist usually notices that the patient has blown off all anesthetic gases and is “bucking” on the tube, indicating it should be removed. The anesthesiologist observes that the lungs are moving just fine, and the patient is extubated. Documentation problems can occur if the anesthesiologist must assist elsewhere and asks an intensivist or hospitalist covering the ICU to oversee the patient. Having been less involved or not involved in the patient’s care, they may incorrectly document acute respiratory failure even if all other circumstances, including extubation, remain the same.

Purposeful maintenance on a ventilator

Physicians sometimes maintain patients under anesthesia and on a ventilator overnight so that they can return to the OR the next day to complete the case. Surgeons who perform liver transplants may delay closure to be certain the transplanted liver is working correctly and to prevent abdominal compartment syndrome. Similarly, patients explored for ischemic disease of the bowel found with occlusion of the arteries to the intestine or those with internal hernias may be packed with their bellies open so that they can return to the OR in a few hours or the next day. Physicians then determine whether the bowel will live or whether it must be resected. Patients maintained on ventilators for these purposes are not in acute respiratory failure.

Warn your chief medical officer, vice president of medical affairs, or medical staff president if physicians incorrectly document acute respiratory failure.

Editor’s note: Dr. Gold is CEO of DCBA, Inc., an Atlanta firm that provides physician-to-physician CDI programs. Contact him at 770-216-9691 or rgold@DCBAInc.com.
IPPS proposed rule

Quality of care emerges as FY 2013 theme

Inpatient hospitals will see CMS payment rates increase 2.3% in FY 2013 if the agency finalizes the change in the IPPS proposed rule released in April. CMS expects that in FY 2013, the documentation and coding adjustment will net an aggregate 0.2% increase. Other quality-of-care initiatives could reduce payments.

Hospital readmissions reduction program

Beginning in FY 2013, CMS will reduce payments for some hospitals with excess readmissions for heart attack, heart failure, and pneumonia. The rule includes methodology for establishing an excess readmission ratio and payment adjustment factors. “Patient noncompliance will be the chief uncontrollable issue. Docs should identify that event and the coders should assign the appropriate ICD code,” says Robert S. Gold, MD, founder and CEO of DCBA, Inc., in Atlanta.

HACs

CMS proposes adding surgical site infection following cardiac implantable electronic device and iatrogenic pneumothorax with venous catheterization to the HAC list. It also wants to add codes 999.32 and 999.33 to the vascular catheter–associated infection HAC category. Coders must be careful when assigning iatrogenic pneumothorax, says Gold. Incidental findings of an apical cap on a chest film after insertion of a central line may or may not have clinical significance. Untreated, it also wouldn’t meet UHDDS criteria for a valid secondary diagnosis, he says.

Other coding changes

As expected, there are no major ICD-9-CM code changes for FY 2013 to facilitate ICD-10 preparations, but there are some notable changes. When coders report principal diagnosis code 487.0 (influenza with pneumonia) with one of several pneumonia codes as a secondary diagnosis, cases will map to MS-DRGs 177–179. They previously mapped to MS-DRGs 193–195.

MS-DRGs 177–179 are higher-weighted than 193–195 and more accurately reimburse hospitals for resources used to treat patients, says William E. Haik, MD, FCCP, CDIP, director of DRG Review, Inc., in Fort Walton Beach, Fla. Coders must capture secondary diagnoses of more specified pneumonia, which may require evaluating sputum cultures and querying for the cause, he says.

CMS proposes adding 263.0 (malnutrition of moderate degree), 263.1 (malnutrition of mild degree), and 440.4 (chronic total occlusion of artery of the extremities) to the CC list. The addition will rectify a likely oversight, says Haik. Previously, unspecified malnutrition, but not the more specific types, was added to the list. CMS also proposes demoting code 584.8 from MCC to CC status.

Quality initiatives

Beginning in FY 2013, CMS will adjust hospital payments annually under the Value-Based Purchasing program based on how well hospitals perform or improve performance on a set of quality measures. The FY 2012 final rule included the initial 13 measures. The FY 2013 proposed rule includes four new measures for FY 2015—statin prescribed at discharge, a patient safety indicator composite measure, a measure related to central line–associated bloodstream infections, and a measure pertaining to Medicare spending per beneficiary.

The proposed rule would increase payment rates 2.3% for facilities that successfully participate in the voluntary Inpatient Quality Reporting program. Those that do not successfully participate would see a 2% point reduction or 0.3% payment rate update. Approximately 95% of hospitals may not receive the full increase in any fiscal year, according to CMS.

Editor’s note: Read the proposed rule at http://tinyurl.com/cs94q5z. CMS will accept comments until June 25. The agency will publish a final rule by August 1.
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.

Editor’s note: Answers to the following questions are based on limited information submitted to Briefings on Coding Compliance Strategies. Review all documentation specific to your scenario before determining appropriate code assignment.

Our question pertains to the following scenario:

The studies section of a history and physical (H&P) indicates that the chest x-ray showed atelectasis or that an electrocardiogram showed right bundle branch block with anterior fascicular block.

Some of us think that coding the diagnosis (i.e., atelectasis) is permissible if the provider states that the testing “showed” the diagnosis. Others think we cannot code the diagnosis because it is a laboratory/testing result, and the provider could just be reading the results into the H&P dictation. We realize coding directly from the testing result itself is impermissible. However, providers use this information to make decisions about care, testing, and procedures, and indicate test results in the H&P. Can you advise us?

These findings are generally incidental and may have no clinical significance. Investigating whether these new findings lead to additional interventions, medications, or more workup is important. If not, they most likely do not meet criteria for coding or reporting.

The mere mention of something doesn’t mean it should be coded. If I review a record and don’t see a direct correlation between a documented diagnosis and orders for care, I query for the clinical significance of the diagnosis.

Copying and pasting diagnostic findings from diagnostic reports into physician notes with no further documentation of clinical significance or treatment plan is occurring more frequently. Be very cautious about coding this information, and consider querying physicians to either confirm or rule out.

Lynne Spryszak, RN, CCDS, CPC, an independent HIM consultant in Roselle, Ill., and Sue Belley, M.Ed., RHIA, CPHQ, project manager at 3M HIS Consulting Services in Atlanta, answered this question, which originally appeared in CDI Strategies.

The patient scenario involves a healing traumatic finger amputation with concern but no diagnosis of infection at the amputation site (the physician prescribed Bactrim™). Is assigning code V54.89 (other orthopedic aftercare) and ICD-9-CM code 886.x (traumatic amputation of finger) appropriate?

ICD-9-CM Official Guidelines for Coding and Reporting indicate four primary circumstances when use of V codes is appropriate. One is reporting aftercare as follows:

A person with a resolving disease or injury, or a chronic, long-term condition requiring continuous care, encounters the health care system for specific aftercare of that disease or injury (e.g., dialysis for renal disease; chemotherapy for malignancy; cast change). A diagnosis/symptom code should be used whenever a current, acute, diagnosis is being treated or a sign or symptom is being studied.

The same coding guidelines address appropriate use of aftercare codes:

Aftercare visit codes cover situations when the initial treatment of a disease or injury has been performed and
the patient requires continued care during the healing or recovery phase, or for the long-term consequences of the disease. The aftercare V code should not be used if treatment is directed at a current, acute disease or injury. The diagnosis code is to be used in these cases.

Now consider the patient with a traumatic finger amputation who presents with an amputation stump and concern about infection at the amputation site. There are no obvious signs and symptoms of infection at the amputation site, and the patient is receiving antibiotics, presumably as a prophylactic measure for infection. In this scenario, aftercare code V54.89 (other orthopedic aftercare) is the most appropriate ICD-9-CM code for this encounter.

The patient’s status is post initial treatment of the traumatic amputation, and the patient is currently in the healing or recovery phase. The physician is not directing current treatment for a current injury. Thus, assigning the 800 code series to indicate a current injury for this encounter is inappropriate.

Assigning V54.89 code along with an acute injury code is similarly inappropriate because assigning aftercare codes when treatment is directed at a current injury is inappropriate. Report code V54.89 only. These code sets should not be reported together.

Glenn Krauss, BBA, RHIA, CCS, CCS-P, CPUR, FCS, PCS, C-CDIS, CCDS, an independent HIM consultant in Madison, Wis., answered this question, which originally appeared on JustCoding.com.

Should I report ICD-9-CM code 701.1 (keratoderma, acquired) or 706.8 (other specified diseases of sebaceous glands) for dry skin due to cold weather? How would I assign this in ICD-10?

The ICD-9-CM tabular list indicates the following:
Dry, dryness—See also condition
Skin syndrome 701.1

Note that the term syndrome is not parenthetical, which means it must be part of a physician’s diagnosis to justify this code assignment. The index does not include a specific entry for dry skin alone. You should query the physician regarding the underlying cause.

Subterms in the description of code 701.1 include ichthyosis, elastosis, hyperkeratosis, keratoderma, and keratosis. This is not a complete list of subterms, but it does seem to encompass dermatologic findings that go well beyond a simple statement of dry skin.

An instructional term near the index entry directs coders to also refer to the condition causing the dryness. The ICD-10-CM index states the following:
Dry, dryness—See also condition

No further entry in this section pertains to dry skin alone. Additional physician clarification is necessary.

Don’t assume other codes, such as 706.8 (other specified diseases of sebaceous glands), would suffice. Neither the ICD-9-CM diagnosis index nor Coding Clinic instructs coders to report 706.8 for dry skin. Consider querying physicians about code 709.8 (other specified disorder of the skin). This code denotes chapped skin, for example.

Jean Stone, RHIT, CCS, coding manager at Lucile Packard Children’s Hospital at Stanford in Palo Alto, Calif., answered the previous question.

Editor’s note: The Coding Clinic reference in the May 2012 Briefings on Coding Compliance Strategies Coding Q&A regarding codes V54.82 and V88.22 should be Fourth Quarter 2011 (not 2001), pp. 156–158.