Facilities have always faced problems related to documentation for cardiorenal syndrome, but an Uptodate article released on Feb. 24, entitled “Cardiorenal Syndrome: Prognosis and Treatment,” brought the diagnosis (and the problematic documentation and query difficulties that frequently accompany it) to the forefront once again, says ACDIS Advisory Board member Wendy Clesi, RN, CCDS, director of CDI Services for Huff DRG Review, Inc., in Eads, Tennessee.

One major problem with the diagnosis is that CDI specialists may query for clarification of cardiorenal syndrome, but physicians and the CDI staff may not clearly understand how each side defines the term. “The coding intent does not correlate with the physician’s definition,” Clesi told ACDIS members during a February 2014 quarterly conference call. (ACDIS members can listen to the conference call recording on the website: http://www.hcpro.com/acdis/quarterly_conference_calls.cfm)

There are a number of important interactions between heart disease and kidney disease. These interactions are bidirectional in nature—meaning that acute or chronic heart failure could cause renal distress or failure, and vice versa. As one might imagine these different interactions have also caused confusion amongst clinicians. So in 2008, a group of physicians got together to propose clinical definitions for five stages of cardiorenal syndrome, published in the Journal of the American College of Cardiology under the title “Cardiorenal Syndrome,” says James Fee, M.D., CCS, CCDS, AHIMA Approved ICD-10 Trainer, associate director of Huff DRG Review, Inc.

The different interactions that can occur led to the following classification of cardiorenal syndrome, as proposed by Dr. Claudio Ronco and colleagues:

» Type 1: Acute heart failure results in acute kidney injury (e.g., renal hypoperfusion in the presence of acute decompensated congestive heart failure)
» Type 2: Chronic cardiac dysfunction (e.g., chronic heart failure) causes progressive chronic kidney disease
» Type 3: Abrupt and primary worsening of kidney function due to renal ischemia or glomerulonephritis, for example, causes acute cardiac dysfunction, which may be manifested by heart failure.

Sample Query for Cardiorenal Syndrome

Editor’s Note: The following sample query was donated by Huff DRG Review, Inc., in Eads, Tennessee.

Patient was admitted for congestive heart failure exacerbation. The patient also had hypotension and an elevated creatinine of 2.9. Creatinine decreased to 1.7 with the treatment of heart failure. There was no documentation of chronic kidney disease. Cardiorenal syndrome was documented. Although the term “cardiorenal syndrome” defaults to category 404, hypertension heart and chronic kidney disease, typically physicians use this term to refer to renal hypoperfusion as opposed to hypertension heart and chronic kidney disease. Therefore, clarification of this diagnosis with the physician is indicated. Query the physician as follows:

» ______ Hypertensive heart and renal disease with congestive heart failure and chronic kidney disease
» ______ Acute kidney injury resulting from renal hypoperfusion secondary to congestive heart failure exacerbation
» ______ Both
» ______ Other
» ______ Unable to provide any further information
Type 4: Primary chronic kidney disease contributes to cardiac dysfunction, which may be manifested by coronary disease, heart failure, or arrhythmia.

Type 5: Secondary acute or chronic systemic disorders (e.g., sepsis or diabetes mellitus) that cause both cardiac and renal dysfunction.

Although the term cardiorenal indexes to 404.x, the definition used by physicians does not always correlate clinically.

“The majority of physicians use a definition that basically is Type 1, which is acute heart failure that results in acute kidney injury,” Garry L. Huff, M.D., CCS, CCDS, AHIMA Approved ICD-10-CM/PCS Trainer president and CEO of Huff DRG says. “So from a clinical standpoint, if cardiorenal syndrome is documented, for the most part they are intending to say the patient has Type 1.”

CDI specialists should converse with their medical staff, however, to develop standards and expectations suitable for their facility and ensure that everyone’s expectations regarding the documentation required are aligned, Clesi says. In some cases there is actually no clinical evidence of chronic kidney disease or hypertensive heart disease. So it is very important for the CDI specialists to understand what the physician means prior to initiating a query.

When querying for clarification of cardiorenal syndrome be sure to include relevant clinical facts and findings with clinically viable menu options. (See the previous page for a sample cardiorenal query scenario provided by Huff DRG).

In addition to querying for clarification of the term, it is equally important to capture all diagnoses through the coding application process.

Correct and specific code assignment can impact the DRG in certain situations, while other diagnoses (chronic kidney disease [specify stage], AKI, etc.) are factored into the risk adjustment models for re-admissions, mortality and other quality outcomes.

EDITOR’S NOTE:

By Sharme Brodie, RN, CCDS

The AHA published its first issue of Coding Clinic for ICD-10-CM and ICD-10-PCS along with its final edition of Coding Clinic for ICD-9-CM.

The AHA editorial board reiterates (on p. 11), that it has no plans to translate all previous issues of Coding Clinic for ICD-9-CM into ICD-10-CM/PCS.

Additionally, this issue reminds readers that clinical information previously published in Coding Clinic—whether for ICD-9-CM or ICD-10-CM/PCS—does not constitute clinical criteria for establishing a diagnosis, substitute for a provider’s clinical judgment, or eliminate the need for provider documentation regarding the clinical significance of the patient’s medical condition.

CDI staff may still find it helpful to know what signs and symptoms are integral (or not integral) to a condition; however Coding Clinic cautions that ICD-10 has new combination codes as well as instructional notes that may not be consistent with ICD-9-CM. Coding Clinic has in the past discussed what documentation can be used for coding, regardless of the coding system being used. Let’s take a look at some of these CDI-related reminders.

Hospital versus physician guidelines

On p. 18 Coding Clinic draws an important distinction between physician (i.e., professional) coding and hospital coding. It states that The Diagnostic Coding and Reporting Guidelines for Outpatient Services (Hospital-Based and Physician Office) are the guidelines coders must follow when coding physician services, regardless of where the services are provided. The inpatient guidelines are for hospital coding.

Coders should report physician services to the highest level of certainty for that encounter/visit, such as signs, symptoms, abnormal test results, or other reason for the visit.