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. (Read the related article on p. 20 of the CDI Journal.) In this Coding Clinic, 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.
The *Official Guidelines for Coding and Reporting*, Section IV.I states, “Do not code diagnoses documented as ‘probable,’ ‘suspected,’ or ‘questionable,’ ‘rule out,’ or ‘working diagnosis’ or other similar terms indicating uncertainty. If a provider documents “evidence of” a particular condition, it is not considered an uncertain diagnosis and would be coded and reported in the outpatient setting.

**Provider Documentation**

On p. 12, *Coding Clinic* reiterated that “code assignment may be based on other physicians (i.e., consultants, residents, anesthesiologist, etc.), providing that there is no conflicting information from the attending, in which case the attending physician’s documentation supersedes all others.

Documentation in the medical record by any physician that is directly involved in the care and treatment of a patient can be used for code assignment. Whether a resident’s documentation needs to be co-signed by the attending is a situation best addressed by the hospital’s internal policies, medical staff bylaws, and/or other applicable local/state/federal regulations.”

The *Official Guidelines for Coding and Reporting* define provider as “the individual legally accountable for establishing a diagnosis.” If a provider is considered legally accountable for establishing a diagnosis within the regulation governing the provider and the facility, then his or her documentation can be used for code assignment and to report a new diagnosis. This would include nurse practitioners and physician assistants’ documentation in the health record.

Documentation is not limited to the face sheet, discharge summary, progress notes, history and physical, or other reports designed to capture diagnostic information. This is true only for inpatient coding. Coders should review the chart in its entirety prior to code assignment. Code assignment should not be based solely on one area of the documentation.

It is appropriate to use the completed cancer staging form for coding purposes when it is authenticated by the attending physician, *Coding Clinic* states.

**Nonphysician Documentation**

*Coding Clinic* also stated that a procedure provided and documented by a nonphysician can be coded. This may be the only evidence that the procedure was performed.

Examples of such procedures include infusions carried out by nursing staff, mechanical ventilation provided by a respiratory therapist, or a drug ordered by a physician and administered by a nurse.

There must be documentation to substantiate the procedure code (again, note that this advice only applies to procedure coding, not diagnosis coding). This guidance reinforces the best practice that CDI specialists examine the complete medical record, including ancillary staff notes, for documentation of any procedures provided by nonphysician personal.

On p. 19, *Coding Clinic* states that if a physician does not document external cause information, coders may use nonphysician documentation. If there is a conflict between the nonphysician and physician documentation, the physician’s documentation takes precedence. *Coding Clinic* also states it is appropriate to use the EMT’s and other nonphysician documentation to determine the Glasgow coma scale, a big bonus in ICD-10 since the separate scores are needed.

**Signs and abbreviations**

As previously advised and reiterated by *Coding Clinic* on p. 13, it is not appropriate for coders to assign a diagnosis based on up and down arrows. Up and down arrows can have different meanings to different people, and could simply mean a change from previous results. Only a provider can diagnose a patient’s condition, so if the provider is using arrows in his or her documentation, query for clarification and ask for appropriate documentation be provided in the medical record.

Per the *Official Guidelines for Coding and Reporting* Section III.B., abnormal findings (i.e., labs, x-rays, pathologic and other diagnostic results) are not to be coded and reported unless the provider indicates their significance. If the findings are found outside the normal range and the primary physician has ordered other tests to evaluate the condition or prescribed treatment, it is appropriate to ask the physician if the diagnosis can be added. This advice applies to both inpatient and outpatient encounters (p.16.)

*Coding Clinic* also gives advice regarding the use of internal guidelines by facilities and stated they should not conflict with the *Official Guidelines for Coding and Reporting*; rather, internal guidelines can promote complete documentation. ☳
By Sharme Brodie, RN, CCDS

In the first quarter of 2014 the AHA published the inaugural issue of a stand-alone Coding Clinic for ICD-10-CM and ICD-10-PCS. Coding Clinic also issued a farewell issue of Coding Clinic for ICD-9-CM at the same time.

This was a very dense, full edition so without further ado, let’s take a look at what was inside.

(See also the related article on p. 16 of the CDI Journal which discusses how Coding Clinic republished important information about how provider documentation can and cannot be used for coding).

Lysis of adhesions

Some of the most important guidance in this issue was given in the area of lysis of adhesions (p. 3) and when they are (and are not) appropriate to capture as the principle procedure or as an additional diagnosis. Coding Clinic says to carefully review the entire operative report to determine the clinical significance of the adhesions and the complexity of the lysis.

According to the ICD-10-PCS Official Guidelines for Coding and Reporting, section B3.1b, adhesions and the lysis of the adhesions should not be coded simply because they are mentioned in the body of the operative note or the title: “They must be clinically significant.”

Documentation of clinical significance by the surgeon may include, but is not limited to, the following language:

» Numerous adhesions requiring a long time to lyse
» Extensive adhesions involving tedious lysis
» Extensive lysis, etc.

The guidance further states that if uncertainty exists regarding clinical significance, you must query. If you’re a CDI specialist covering a surgical unit, look at the verbiage used within the operative note and decide if it’s clear whether the adhesions present were lysed as an integral part of a procedure—did they increase the difficulty of the procedure, or were they an incidental finding?

One clue would be to look at the amount of time the surgery required—was it longer than what it normally would have taken the surgeon to complete? If yes, ask why. Read the entire operative note and look for wording such as “dense or extensive” adhesions. Speak to the surgical staff or observe an actual procedure to get a better understanding of it.

Additional PCS difficulties

There are 31 different root operations in ICD-10-PCS. It is a coder’s responsibility to determine what the documentation in the medical record equates to in the PCS definitions; each unique procedure has its own code. Physicians will not be expected to use the terms used in PCS code description. Instead, coders need to know what the intent of the procedure is despite what the physician may document. This is brand new for coders who will have to memorize all the definitions of the root operations and apply them accurately.

Coders and CDI will need to know what a physician’s intent was in performing the surgery. Again, it may not be a bad idea for coders and CDI to observe some surgical procedures and become familiar with how they are carried out.

Advice for payment disputes

Coding Clinic does not usually address coding for reimbursement, but this edition offers some interesting advice (on p. 17) to help providers resolve coding disputes with payers. First, make sure the dispute is actually a coding dispute. Second, always contact payer for clarification if the reason for denial is unclear. Third, provide the applicable coding rule/guideline to payer. If a payer has a policy that conflicts with the official coding rules and refuses to change their policy, the facility should request the payer’s requirements in writing. If the payer refuses to provide the policies, the facility should document all discussions including dates and times and the names of individuals involved. Confirm the existence of the policy with supervisory personnel. Finally, keep a permanent record of documentation obtained in case of an audit.

Documentation for gestational age

On p. 14, Coding Clinic addresses documentation for gestational age for a newborn. In these instances the
Linking conditions

On p. 15 Coding Clinic provides advice regarding the linkage of two conditions. This guidance remains the same; the physician needs to use linking language, except for situations where the classification assumes the link (e.g., hypertension with chronic kidney involvement). Just because a patient has two conditions that commonly occur together does not mean that the conditions are related. If the documentation is unclear whether two conditions are related, you must query the physician.

Neurologic deficits

As in ICD-9, any neurologic deficits caused by a cerebrovascular accident (CVA) should be coded even if resolved at the time of discharge in ICD-10 (p. 23). This entry also states that hemiplegia is not inherent to an acute CVA.

Heart failure

Finally, on p. 25 Coding Clinic states that if a physician documents heart failure with preserved ejection fraction (HFpEF), heart failure with preserved systolic function, heart failure with reduced ejection fraction (HFrEF), heart failure with low ejection fraction, heart failure with reduced systolic function, or other similar terms, a coder cannot assume either systolic or diastolic failure or a combination of both, based on these new terms.

As a CDI specialist, you must query the physician to clarify what type of heart failure the patient has.

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