PHYSICIAN ADVISOR’S CORNER

Clinical versus coding definitions: Addressing challenges associated with difficult translations

by Trey La Charité, MD

When providers use different definitions for the same disease, confusion and chaos result. Inaccurate definitions allow Recovery Auditors (i.e., RACs) ample opportunities for denials, depriving your facility of valuable dollars/patient care resources. Unfortunately, providers learn disease definitions during medical training. When they begin practice, adopting new disease definitions or accepting terminology changes proves difficult.

As CDI professionals, guiding your facility’s providers toward more accurate disease definition usage is challenging, frustrating, and an ongoing process. And yet, maintaining accurate and consistent definitions of medical diagnoses is an important aspect of the CDI specialist’s role.

Definitions of medical diagnoses are rarely permanent; they change over time as our understanding of disease pathophysiology, recognition, and management evolves.

This creates a significant challenge for CDI professionals and the providers with which they work. Since there is no uniform method for distributing medical information, adoption and implementation of changes vary tremendously between providers. For the CDI professional, this poses two problems:

1. Providers who fail to learn and apply new definitions (and continue to use outdated terminology)
2. Providers who adopt new terminology faster than the ICD system can create corresponding codes

Outdated terminology may lead to unnecessary down-coding; using terminology with no corresponding ICD code may lead to a diagnosis not being reported.

Both problems can lead to providers not receiving appropriate credit for the severity of illness of their patients.

Changes in heart failure definitions

Let’s look at heart failure, for example. Starting in the late 1980s, the pathophysiology of congestive heart failure (CHF) shifted from the classic left-sided versus right-sided designations taught in basic physiology courses to the concept of systolic function versus diastolic function.

Documenting CHF as either systolic or diastolic (in addition to being described as acute or chronic) allows coders to assign the most specific and highest weighted codes possible in our current ICD-9-CM coding system.

However, if a clinician uses non-specific, outdated terminology such as “CHF exacerbation” or “acute left-sided CHF,” the corresponding ICD-9-CM code(s) are lower-weighted, the patient doesn’t appear to be as ill, and the physician appears to not have done as much work to provide care to that individual.

Additionally, the financial ramifications for a healthcare institution can be significant, as “acute systolic CHF” is an MCC, “acute left-sided CHF” is a CC, and “CHF exacerbation” is neither.

On the other end of the spectrum, consider a clinician that has already adopted the new heart failure terminology proposed by both the American College of Cardiology and the American Heart Association in 2013. (Read the report, “ACCF/AHA Guideline for the Management of Heart Failure: A Report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines.”

In this new taxonomy, heart failure has been subdivided into “heart failure with reduced ejection fraction” and “heart failure with preserved ejection fraction.” (These new phrases are invariably abbreviated in the medical record simply as “HFrEF” and “HFpEF.”) Currently, there are no corresponding ICD-9 or ICD-10 codes for these
descriptors. Therefore, if these terms are used by providers, coders may only code “congestive heart failure, unspecified” (428.0), which does neither the clinician nor their host hospital any good.

In fact, Coding Clinic for ICD-10-CM/PCS, First Quarter 2014, p. 25, stated that coders may not assume that “HFrEF” and “HFpEF” mean “systolic” or “diastolic” heart failure. For clinicians that practice in an academic institution, this can be a very difficult situation.

Continuing with the heart failure example, what is the appropriate terminology that cardiologists and other providers should use when training medical students, residents, and fellows? Must a university-based healthcare system that emphasizes cutting-edge care use out-of-date terminology to satisfy the coding needs of the hospital?

This can be a bitter pill to providers who see themselves as guardians of the famed academic ivory tower. The cardiologists at my academic institution were unhappy when instructed to stop writing “HFpEF” and “HFrEF” in the medical record and return to “systolic” and “diastolic” descriptors they now consider archaic. As they are responsible for educating our future physicians, their frustration is justifiable.

Changes in renal failure definitions

As a second example, let’s consider acute renal failure. For years, the definitions for this diagnosis varied widely. Finally, in 2004, the RIFLE criteria—Risk, Injury, Failure, Loss, End-Stage Renal Disease—was proposed by the Acute Dialysis Quality Initiative Group (ADQI), yielding one uniform definition for diagnostic accuracy. (Read the related literature online at www.ncbi.nlm.nih.gov/pubmed/15312219.)

However, by 2012, the Kidney Disease Improving Global Outcomes (KDIGO) work group rewrote the definition and proposed the new terminology of “acute kidney injury” (AKI). (Visit www.kdigo.org for additional information.)

While this change was instituted to facilitate provider recognition that even small changes in kidney function have significant clinical consequences, this taxonomy created a significant coding and reporting problem for our hospitals.

Acute renal failure, as defined by the RIFLE criteria, referred to creatinine levels that were three times higher than a patient’s baseline level, or to a 75% decrease in a patient’s glomerular filtration rate (GFR).

In contrast, the entire spectrum of acute renal dysfunction, including increases in creatinine levels of only 0.3 mg/dl up to the acute need for continuous renal replacement therapy (CRRT), is now covered by the single “acute kidney injury” term. (For the simplicity of my arguments, I have intentionally omitted the urine output components of these definitions.)

In the current ICD system, however, when a provider writes AKI in the medical record, the corresponding code remains acute kidney failure (584.9). Therefore, for a relatively small rise in a patient’s creatinine, the hospital submits a code designated as a CC.

If a patient’s creatinine only increased from 1.1 to 1.4 and was only treated with two bags of IV fluids, is this really an accurate portrayal of a patient’s severity of illness? Should the hospital receive the associated increased reimbursement?

As the RIFLE criteria are now clinically obsolete, AKI should have a corresponding ICD code. In fact, AKI as defined by the KDIGO includes three stages of severity based on increasing serum creatinine levels. Therefore, we should have an appropriately corresponding ICD code for each stage.

My suggestion is to create three new codes labeled AKI Stage 1 (being neither a CC or an MCC), AKI Stage 2 (being a CC), and AKI Stage 3 (being an MCC). This would ensure an accurate description of a patient’s clinical situation and appropriately compensate hospitals for the varying degrees of resource use required to treat each stage. Code changes such as these fall under the auspices of the ICD Coordination and Maintenance Committee; CDI professionals and clinicians must wait for them to take action on this subject.

CDI leverage

A CDI professional recognizes that his or her institution’s providers attended different training programs.
Therefore, they expect a certain degree of variability in how each provider establishes the presence of a certain diagnosis. However, the CDI professional also needs to be charged with standardizing (as much as possible) the definitional criteria used by their providers across the entire institution. When disease definition or nomenclature changes occur, the CDI team needs to quickly implement an efficient and effective communication plan.

CDI programs can establish a regular cadence to review any standardized queries and update them according to clinical and coding definition changes. While a quarterly review may be too onerous (and potentially unnecessary), such examinations should be conducted at a minimum whenever clinical or coding definitions change.

Additionally, many facilities work with their coders and physicians within a given specialty to regularly review definitions for common diagnoses such as those mentioned here. In such a collaborative forum, all sides are able to discuss the needs and problems associated with definition variances and establish mutually agreeable terms for the facility to use.

Ideally, the ICD system would have the involvement and agility to modify or create code sets that correspond to these changes soon after they occur. However, until that happens, the CDI professional has to navigate a utilitarian, yet as compliant as possible, course within their facility.

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