CDI in Transition

Spectrum of Opportunity

MoHiMA
Missouri Health Information Management Association

Breaking Bad Habits for ICD 10 Queries

Presented by:

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Objectives

At the end of this presentation, you should be able to:

1. Adapt outdated queries to new documentation requirements
2. Identify query-related changes to meet ICD-10 coding related nuances
3. Establish updated query templates
4. Identify unspecified diagnoses that lower severity
5. Establish effective education to increase the clinical validity of queries and reduce query fatigue

Focus Areas for Discussion

1. What are some examples of outdated queries?
2. What are some examples of ICD-10 coding “quirks”?
3. What are some examples of new ICD-10 queries?
4. What are a few examples specific to ICD-10 where a lack of specificity results in lower severity?
5. What does “Increase the validity of a query” even mean?

More New Paradigms in ICD-10

PDX that acts as own MCC

- Traumatic Cerebral Edema
- Saddle Pulmonary Embolism with Acute Cor Pulmonale
- CMV Pancreatitis
- Candidal Sepsis

Image Reference: Rido / Shutterstock

PDX that acts as own CC

- Diverticulosis with perforation and abscess
- CMV Hepatitis
- Hydronephrosis w ureteral stricture, NEC

What does this mean?

- In rare circumstances a single diagnosis code will lead you to a DRG that is "with CC" or "with MCC"
- Reference: Optum360 DRG Expert 2016 and CMS.gov

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Breaking the Bad Habits: Outdated Queries

- Diabetes: Uncontrolled vs Controlled
  - Hypoglycemic vs Hyperglycemic
- Hypertension: Accelerated and Malignant
  - Transient Confusion: Hypertensive Encephalopathy?
- Hepatic Encephalopathy: Not Reportable in ICD 10
  - Hepatic Coma
  - Metabolic Encephalopathy is not an excludes 1
  - Toxic Liver diagnosis is an excludes 2 and may be reported with Alcoholic Liver Disease
- Pathological Fracture in the Absence of Osteoporosis, Congenital Bone Disease and Cancer?
  - What is the mechanism?

Clinical documentation improvement is at the heart of ICD-10 compliance

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Coding Guideline

•Guideline I.C.13.d(2)

•Osteoporosis with Current Pathological Fracture Category M80

- Osteoporosis with current pathological fracture, is for patients who have a current pathologic fracture at the time of an encounter.
- The codes under M80 identify the site of the fracture and should be used for any patient with known osteoporosis who suffers a fracture, even if the patient had a minor fall or trauma, if that fall or trauma would not usually break a normal, healthy bone.

Definitions

- Fragility fracture (Category M80):
  - Sustained with trauma no more than a fall from a standing height or less occurring under circumstances that would not cause a fracture in a normal healthy bone

Coding Guideline in ICD-10-CM: Encounters

Coding Guideline 1.C.19.c.1

- Traumatic fractures are coded using the appropriate 7th character for initial encounter (A, B, C) while the patient is receiving **active treatment** for the fracture.
  - Examples of active treatment are:
    - surgical treatment
    - emergency department encounter
    - evaluation by physician
- The appropriate 7th character for initial encounter should also be assigned for a patient who delayed seeking treatment for the fracture or nonunion.
- While the patient may be seen by a new or different provider over the course of treatment for an injury, assignment of the 7th character is based on whether the patient is undergoing active treatment and not whether the provider is seeing the patient for the first time.

ICD 10 Indexing Issue

PVD = ARTERIAL disease!

Index: Disease: peripheral vascular NOS I73.9

Tabular: I73.9: Peripheral Vascular Disease Unspecified
Includes: Intermittent Claudication
Peripheral angiopathy NOS
Spasm of artery

Warning

The term “PVD” is often used to describe VENOUS disease, therefore if we default to the standard PVD index above, we are reporting the wrong code for the patients pathology.

Breaking the Bad Habits: Outdated Queries

- General PVD
  - Disease of Arteries (Angiopathy of Diabetes)
  - Disease of the Veins
- Septic Shock with the only indicator being IVF
  - Standard for Sepsis = 30mg/kg over 6 hours
- Encephalopathy during the post ictal period
  - The symptomology is intrinsic to the condition already being reported

Clinical documentation improvement is at the heart of ICD-10 compliance

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Not Reportable in ICD-10

Medical record	Documentation
Documentation is the same, the coding convention is different	• Acute Cor Pulmonale in Absence of PE (was reportable in ICD 9) • Intractable Vomiting in Absence of Migraine (was reportable in ICD 9) • Demand Mediated MI • Type II MI • Peptic ulcer disease with obstruction (was reportable in ICD 9) • DKA in DMII (was reportable in ICD 9) • Esophageal Hemorrhage (was reportable in ICD 9: 530.82) • Functional CHF status (NYHA and ACC classifications)
ICD 10 Issues	
ICD 10 less specific in some areas than ICD 9	

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Coding Clinic

Seizure with Encephalopathy due to Postictal State

Fourth Quarter, 2013, Page 89

….the encephalopathy due to postictal state is not coded separately since it is integral to the condition. Seizure activity may be followed by a period of decreased function in regions controlled by the seizure focus and the surrounding brain. The postictal state is a transient deficit, occurring between the end of an epileptic seizure and the patient's return to baseline. This period of decreased functioning in the postictal period usually lasts less than 48 hours.

Coding Clinic

Encephalopathy due to Diabetic Hypoglycemia

Third Quarter, 2015, Page 21

Question: A patient with diabetes mellitus was admitted when she was found to be lethargic. Her blood sugar readings were low. Discharge diagnosis was documented as acute encephalopathy secondary to hypoglycemia. What are the diagnosis code assignments for encephalopathy due to hypoglycemia in a diabetic patient?

Answer: Assign code E11.649, Type 2 diabetes mellitus with hypoglycemia without coma, as the principal diagnosis. Assign also code G93.41, Metabolic encephalopathy, as an additional diagnosis.

Coding advice or code assignments contained in this issue effective with discharges October 7, 2015

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Get On Board with ICD-10 Coding Changes

ICD-9	ICD-10
• Sundowning: No code	• Sundowning: F05 = CC
• Subsequent MI: Almost never a PDX	• Subsequent MI: Will be PDX and the Initial MI with a POA of Y will be secondary
• Old MI: Not severity-ranked	• MI may qualify an MCC for 28 days
• 2 (Closed) Fractured Ribs: Other Respiratory System Diagnoses	• 2 (Closed) Fractured Ribs: Major Chest Trauma
• Acute Cor Pulmonale = MCC	• Acute Cor Pulmonale: Not reportable in the absence of a Pulmonary Embolism
• Sepsis: 2 codes (3 for severe)	• Sepsis: 1 code (2 for severe)
• SVT: General Cardiac Arrhythmia	• SVT: Defaults to a CC
• Urosepsis: UTI	• Urosepsis: Nothing
	– Pyuria: Indexes to a UTI
• Anemia with Cancer; Anemia is PDX	• Anemia with Cancer: Cancer is PDX

ICD-10 and Documentation

Clarification Regarding What Can Be Reported Together

Excludes 1

Not coded together; mutually exclusive. You can code one condition or the other, but not both.

Excludes 2

Both conditions may be reported together. You may or may not choose to add the additional code, depending on the documentation. If the documentation justifies both conditions, please add the additional code.

Coding Clinic

Interim Coding Advice on Excludes 1, Notice

Fourth Quarter, 2015, Page 40

The National Center for Health Statistics (NCHS), the Federal agency responsible for use of the ICD-10-CM in the United States has issued interim advice as it pertains to excludes 1 notes and unrelated conditions. The following information can be found on the NCHS website.

There are circumstances that have been identified where some conditions included in Excludes 1 notes should be allowed to both be coded, and thus might be more appropriate for an Excludes 2 note. However, due to the partial code freeze, no changes to Excludes notes or revisions to the official coding guidelines can be made until October 1, 2016. The new guidance concerning Excludes 1 notes is intended to allow conditions to be reported together when appropriate even though they may currently be subject to an Excludes 1 note.

Coding Clinic

Interim Coding Advice on Excludes 1, Notice

Fourth Quarter, 2015, Page 40

Question: We have received several questions regarding the interpretation of Excludes 1 notes in ICD-10-CM when the conditions are unrelated to one another.

Answer: If the two conditions are not related to one another, it is permissible to report both codes despite the presence of an Excludes 1 note. For example, the Excludes 1 note at the code range R40-R46, states that symptoms and signs constituting part of a pattern of mental disorder (F01-F99) cannot be assigned with the R40-R46 codes. However, if dizziness (R42) is not a component of the mental health condition (e.g, dizziness is unrelated to bipolar disorder), then separate codes may be assigned for both dizziness and the mental disorder.

In another example, code range I60-I69 (Cerebrovascular Disease) has an Excludes 1 note for traumatic intracranial hemorrhage (S06-). Codes in I60-I69 should not be used for a diagnosis of traumatic intracranial hemorrhage. However, if the patient has both a current traumatic intracranial hemorrhage and sequela from a previous stroke, then it would be appropriate to assign both a code from S06- and I69-.

Coding advice or code assignments contained in this issue effective with discharges November13, 2015

Ventilation Hours

SA1935Z
Respiratory Ventilation < 24 Consecutive Hours

SA1945Z
Respiratory Ventilation 24-96 Consecutive Hours

SA1955Z
Respiratory Ventilation > 96 Consecutive Hours

ICD 10 Indexing Issue

Acute Respiratory Distress is NOT ARDS!

Index: Distress: - Acute Respiratory (adult) (child): J80

Tabular: J80: Acute respiratory distress syndrome
Includes: Acute respiratory distress syndrome in adult or child
Adult hyaline membrane disease

Warning
Acute Respiratory Distress and Acute Respiratory Distress Syndrome are two completely different pathological processes with completely different treatment, prognosis, and resource utilization

What's New in ICD-10

Atrial Fib is now a CC!

- Chronic Atrial Fib = >1 yr. (with acceptance by patient and physician not to treat): Not a CC
- Persistent Atrial Fib = Continuous Afib for >7 days or <1yr (persistent long standing) = CC
- Paroxysmal Atrial Fib = Self Limited or Successfully treated transient Atrial Fib is not a CC

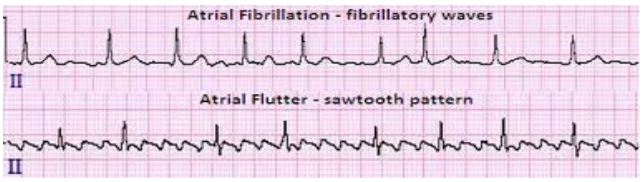
*2014 Guidelines for the Management of Patients With Atrial Fibrillation

• Image Reference: amasterphotographer / Shutterstock

Cardiac Dysrhythmia

Clinical Tip

- Check EKG recordings for the classic "saw tooth" EKG pattern of Atrial flutter
- Atrial fibrillation is not a complication or comorbidity, but Atrial flutter is (and is some times still referred to as a-fib)
- Additional Cardiac diagnoses that qualify as a comorbidity: Bilateral Bundle Branch Block, Trifascicular Block, 2nd Degree Type II Heart Block, Complete Heart Block and Sick Sinus Syndrome



ICD-10 Coding Shifts

Medical record

Documentation is the same, the coding convention is different

Education

Understanding is sometimes just as important as identifying a query

Documentation

- MI Unspecified: Defaults to STEMI
  - Quality concern; physicians must call out NSTEMI
- Chronic Pulmonary Insufficiency Following Surgery – MCC
  - When do you use it?
- Persistent A-Fib
  - What differentiates persistent from chronic?
- Unspecified Shock – CC
  - If the physicians know the reason for the shock, then the reported code should always be "Other" MCC
- CAD with Angina
  - Now just one code
- Diabetes and Osteomyelitis: No longer an assumed relationship (4th Q 2014, p. 114)

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ICD-10 Changes Result in DRG Shifts

ICD-9

- Index: Vomiting: cyclical- Not psychogenic- no associated migraine: 536.2 Persistent Vomiting
- DRG 390-392 Esophagitis, gastroenteritis and MISC Digestive Diseases

ICD-10

- Index: Vomiting: cyclical G43.A0
- DRG 101 – 103 Headache

Warning

In ICD 9. Cyclical Vomiting was a GI Diagnosis. In ICD 10 Cyclical Vomiting is a Neurological Diagnosis

ICD 10 Problems

OPTUM360

ICD-10 Changes Result in DRG Shifts

ICD-9	ICD-10
• Index: Obesity – Morbid 278.01 • Index: Banding – Gastric – Adjustable Laparoscopic 44.95 • DRG 621 OR Procedure for Obesity wo CC/MCC	• Index: Obesity Hypoventilation Syndrome E66.2 • Index: Banding: Restriction Gastrointestinal Stomach Extraluminal device percutaneous endoscopic 0DV64CZ • DRG 989 Non-ext OR Procedure unrelated to principle diagnosis **Warning** In ICD 10. New Diagnosis codes including combinations are improperly grouped to incorrect DRG assignments by CMS. No Fix.

ICD 10 Problems

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Coding Clinic

Heart Failure with Preserved Ejection Fraction and Heart Failure with Reduced Ejection Fraction

First Quarter 2016 Page: 10

Question: Please reconsider the advice previously published in *Coding Clinic,* First Quarter 2014, page 25, stating that the coder cannot assume either diastolic or systolic failure or a combination of both, based on documentation of heart failure with preserved ejection fraction (HFpEF) or heart failure with reduced ejection fraction (HFrEF). Would it be appropriate to code diastolic or systolic heart failure when the provider documents HFpEF or HFrEF?

Answer: Based on additional information we received from the American College of Cardiology (ACC), the Editorial Advisory Board for Coding Clinic for ICD-10-CM/PCS has reconsidered previously published advice about coding heart failure with preserved ejection fraction (HFpEF), and heart failure with reduced ejection fraction (HFrEF). HFpEF may also be referred to as heart failure with preserved systolic function, and this condition may also be referred to as diastolic heart failure. HFrEF may also be called heart failure with low ejection fraction, or heart failure with reduced systolic function, or other similar terms meaning systolic heart failure. These terms HFpEF and HFrEF are more contemporary terms that are being more frequently used, and can be further described as acute or chronic.

Therefore, when the provider has documented HFpEF, HFrEF, or other similar terms noted above, the coder may interpret these as “diastolic heart failure” or “systolic heart failure,” respectively, or a combination of both if indicated, and assign the appropriate ICD-10_CM codes.

Coding advice or code assignments contained in this issue effective with discharges March 18, 2016.

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Coding Clinic

Postoperative Coagulopathy Secondary to Medication

First Quarter 2016 Page: 15

Question: This patient underwent an emergency ileocecectomy. The patient's stay was complicated by postoperative coagulopathy and intra-abdominal hemorrhage due to prasugrel and aspirin taken as prescribed prior to admission. What is the appropriate code for the actual coagulopathy secondary to prasugrel and aspirin?

Answer: Assign code D68.32, Hemorrhagic disorder due to extrinsic circulating anticoagulants, along with codes T45.525A, Adverse effect of antithrombotic, Initial Encounter, T39.015A, Adverse effect of aspirin, Initial encounter.

Prasugrel (Effient) is a platelet inhibitor and works by keeping the platelets in the blood from coagulating to prevent unwanted blood clots that can occur with certain heart or blood vessel conditions. It is used to prevent blood clots in people with acute coronary syndrome who are undergoing a procedure after a recent heart attack.

Coding advice or code assignments contained in this issue effective with discharges March 18, 2016.

D68.32 Hemorrhagic disorder due to extrinsic circulating anticoagulants

- Drug-induced hemorrhagic disorder
- Hemorrhagic disorder due to increase in anti-IIa
- Hemorrhagic disorder due to increase in anti-XA
- Hyperheparinemia
- Use Additional code for adverse effect, if applicable to identify drug (T45.515, T45.525)

Know The Includes Notes

ICD-10 Indexing Issue

CLL is Not B Cell Leukemia!

Incorrect Indexing: Leukemia: - Chronic lymphocytic, of B-Cell type C91.1

Correct Indexing: Leukemia – Unspecified Cell Type Chronic C95.1

DRG Changes for ICD-10

ICD-10

- Seven new MS-DRGs in MDC 5 – Surgical Section
  - DRG 268 to 269: Aortic and Heart Assist Procedures Except Pulsation Balloon (with or without MCC)
  - DRG 270 to 272: Other Major Cardiovascular Procedures (with CC/MCC or without)
  - DRG 273 to 274: Percutaneous Intracardiac Procedures (with and without MCC)
- Deleted DRGs 237 to 238 (Major Cardiac Procedures with and without MCC)
- Added 43 ICD-10-CM diagnosis codes to the manifestation codes not allowed as principal diagnosis (2017 MCE)
- Revised MCE edit language for Procedure Inconsistent with Length of Stay to read "The following procedure code should only be coded on claims with a length of stay greater than 4 days" which includes Mechanical Vent = or > 96 Hours
- Added two ICD-10-CM codes to the list of procedures that can act as their own CC, N13.1 (Hydronephrosis with ureteral stricture NEC) and N13.2 (Hydronephrosis with renal and ureteral calculus obstruction)
- Recalibrated the DRG relative weights as required by the Social Security Act
- No revisions to the CC, MCC or CC excludes list

Missing Coding/Query Opportunity

- Do you have an unexplained drop in Hgb/Hct in the absence of Blood Loss?
  - Is the physician documenting the clinical significance of increased monitoring, diagnostics, patient symptomology or treatment?
- Index: Drop – Drop in Hemoglobin:
  - R71.0 Precipitous Drop in Hematocrit

Source:
ICD-10-CM Official Index

Major Guideline Changes

- A symptom(s) followed by contrasting/comparative diagnoses
- **GUIDELINE HAS BEEN DELETED EFFECTIVE OCTOBER 1, 2014**

Source:
ICD-10-CM Official Guidelines for Coding and Reporting
FY 2016

Keep Up-to-Date with Coding Clinic in ICD-10

Right Sided Weakness from a Stroke = Hemiplegia and Hemiparesis following Cerebral Infarction! = CC

- Question: The patient is a 72-year-old male admitted to the hospital because of gastrointestinal bleeding. The provider documented that the patient had a history of Acute Cerebral Infarction with Residual Right-sided Weakness (dominant side), and ordered an evaluation by physical and occupational therapy. What is the appropriate code assignment for residual right-sided weakness, resulting from an old CVA without mention of hemiplegia/hemiparesis?

Don't get your Coding Rules second hand. Get them straight from the Source!

Coding Clinic: 1st Q 2015 Pg. 5

Keep Up-to-Date with Coding Clinic in ICD-10

Right Sided Weakness from a Stroke = Hemiplegia and Hemiparesis following Cerebral Infarction! = CC

- Answer: Assign code I69.351, Hemiplegia and Hemiparesis following Cerebral Infarction, Affecting Right Dominant Side, for the residual right-sided weakness due to cerebral infarction. When unilateral weakness is clearly documented as being associated with a stroke, it is considered synonymous with Hemiparesis/Hemiplegia. Unilateral weakness outside of this clear association cannot be assumed as Hemiparesis/Hemiplegia, unless it is associated with some other brain disorder or injury.

Don't get your Coding Rules second hand. Get them straight from the Source!

Coding Clinic: 1st Q 2015 Pg. 5

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Coding Clinic

Bronchoalveolar Lavage, Endobronchial Biopsy and Transbronchial Biopsy

First Quarter 2016 Page: 26

Question: A bronchoscopy is performed, bronchoalveolar lavage (BAL), bronchial washings and cytology brushings were obtained in the right upper lobe bronchus; endobronchial biopsies and transbronchial biopsies from the right upper lobe; and bronchoalveolar lavage samples were obtained from the left lower lobe. Should the BAL and brushings be separately coded?

Answer: "Brushings" are coded to the root operation "Excision" and "lavage" is coded to the root operation "Drainage." Since ICD-10-PCS does not provide the "Extraction" root operation value for bronchial brush biopsies, the root operation Excision is the closest available equivalent. Assign the following ICD-10-PCS codes for the procedures performed:

0BB48ZX Excision of right upper lobe bronchus, via natural or artificial opening endoscopic, diagnostic, for the right upper lobe brush biopsies, washings and endobronchial biopsies Does not move to Surgical DRG

0B948ZX Drainage of right upper lobe bronchus, via natural or artificial opening endoscopic, diagnostic, for the bronchoalveolar lavage of the right upper lobe Does not Move to Surgical DRG

0BBC8ZX Excision of right upper lung lobe, via natural or artificial opening endoscopic, diagnostic, for the transbronchial biopsies of the right upper lobe **Moves to DRG 166 to 168**

0B9B8ZX Drainage of left lower lobe bronchus, via natural or artificial opening endoscopic, for the bronchoalveolar lavage of the left lower lobe

Bronchoalveolar lavage can be found in the ICD-10- PCS' Index to Procedures under: Does not move to Surgical DRG

Note: BAL with Drainage not diagnostic (ex. 0B968ZZ) moves to DRG 165

Lavage
Bronchial alveolar, diagnostic *see* Drainage, Respiratory System **0B9**

Coding advice or code assignments contained in this issue effective with discharges March 18, 2016.

BAL Procedures

- Grouper V.33 is moving these procedures to DRG 166 or 168

We will continue to get inappropriate assignments to DRG 166

Coding Clinic

Diabetic Foot Ulcer

First Quarter 2016 Page: 12

Question: A patient, who is a type 2 diabetic, is admitted with a chronically infected ulcer of the left mid-foot. The provider documented, "Diabetic foot ulcer with skin breakdown, positive for Methicillin resistant Staphylococcus aureus (MRSA) infection." She also had been diagnosed with polyneuropathy, end-stage renal disease (ESRD), on hemodialysis maintenance. Does the ICD-10-CM assume a cause-and-effect relationship between the diabetes mellitus, the foot ulcer, polyneuropathy and ESRD? How should this case be coded?

Answer: ICD-10-CM assumes a causal relationship between the diabetes mellitus and the foot ulcer, the polyneuropathy, as well as the chronic kidney disease. Assign code E11.621, Type 2 diabetes mellitus with foot ulcer, as the principal diagnosis. Codes L97.421, Non-pressure chronic ulcer of left heel and midfoot limited to breakdown of skin; E11.42, Type 2 diabetes mellitus with diabetic polyneuropathy; B95.62, Methicillin resistant Staphylococcus aureus infection as the cause of disease classified elsewhere; E11.22, Type 2 diabetes mellitus with diabetic chronic kidney disease; N18.6, End stage renal disease; and Z99.2, Dependence on renal dialysis, should be assigned as additional diagnoses.

Coding advice or code assignments contained in this issue effective with discharges March 18, 2016.

Coding Clinic

Duodenal Ulcer with Hemorrhage due to Anticoagulant Therapy

First Quarter 2016 Page: 14

Question: What is the code assignment for duodenal ulcer with hemorrhage due to Coumadin therapy, initial encounter? Is D68.32, Hemorrhagic disorder due to extrinsic circulating anticoagulant, assigned for bleeding that is due to anticoagulation therapy?

Answer: Assign codes K26.4, Chronic or unspecified duodenal ulcer with hemorrhage, D68.32, Hemorrhagic disorder due to extrinsic circulating anticoagulant, and T45.515-, Adverse effect of anticoagulants. Depending on the circumstances of the admission, it may be appropriate to sequence either K26.4 or D68.32 as the principal or first listed diagnosis.

An increased risk for bleeding is a side effect associated with anticoagulant therapy. The adverse effect code is assigned for bleeding resulting from an anticoagulant that is properly administered.

Coding advice or code assignments contained in this issue effective with discharges March 18, 2016.

ICD 10 Indexing Issue

Acute Infective Psychosis!

Index: Distress: - Psychosis - Infective - Acute F05

Delirium superimposed on dementia: Cannot be Indexed in a book, but can in an encoder

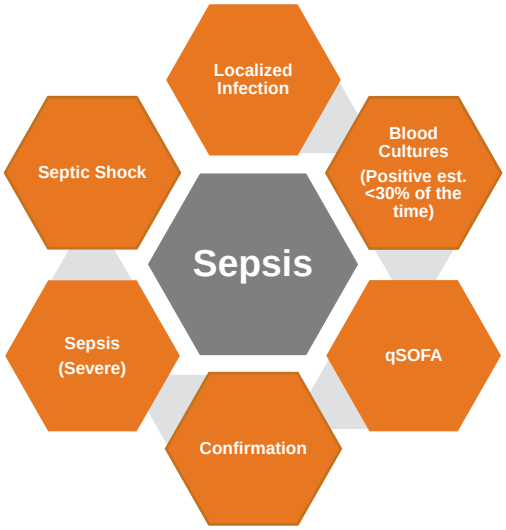
Warning

Audits and education are showing coders are not reading their includes notes and are not aware of what is in the includes notes for certain ICD 10 Diagnoses

F05: Delirium due to known physiological conditions

ICD-10	Includes
F05	Acute and Subacute Brain Syndrome
	Acute and Subacute Confusional State (non-alcoholic)
	Acute and Subacute Infective Psychosis
	Acute and Subacute Organ Reaction
	Acute and Subacute psycho-organic syndrome
	Delirium of Mixed Etiology
	Delirium Superimposed on Dementia
	Sun downing

The Sepsis Continuum



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Sepsis

Organ dysfunction can be identified as an acute change in total SOFA (Sepsis related Organ Failure Assessment) score greater than or equal to 2 points consequent to the infection:

- Baseline SOFA score can be assumed to be zero in patients not known to have preexisting organ dysfunction.
- A SOFA score greater than or equal to 2 reflects an overall mortality risk of approximately 10% in general hospital population with suspected infection. Even patients presenting with modest dysfunction can deteriorate further, emphasizing the seriousness of this condition and the need for prompt and appropriate intervention, if not already instituted.

Patients with suspected infection who are likely to have a prolonged ICU stay or to die in the hospital can be promptly identified at the bedside with qSOFA (quick) Sequential Sepsis Related Organ Failure Assessment.

Diagnostics

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Sepsis

To assist the bedside clinician, and perhaps prompt an escalation of care if not already instituted, simple clinical criteria (qSOFA) that identify patients with suspected infection who are likely to have poor outcomes, that is, a prolonged ICU course and death, have been developed and validated. (Must have 2 of the 3) for suspected Sepsis.

qSOFA Criteria:

- Respiratory Rate > 22/min
- Altered mental Status
- Systolic blood pressure less than or equal to 100

- Optional Criteria (High predictor of organ dysregulation)
  - Lactate > 2

•CDI Alert

•Positive qSOFA criteria in the presence of infection should generate an automatic Suspected Sepsis Query

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SOFA

Table 1. Sequential [Sepsis-Related] Organ Failure Assessment Score[a]

	Score				
System	0	1	2	3	4
Respiration					
PaO_2/FIO_2, mm Hg (kPa)	≥400 (53.3)	<400 (53.3)	<300 (40)	<200 (26.7) with respiratory support	<100 (13.3) with respiratory support
Coagulation					
Platelets, $\times 10^3/\mu L$	≥150	<150	<100	<50	<20
Liver					
Bilirubin, mg/dL (μmol/L)	<1.2 (20)	1.2-1.9 (20-32)	2.0-5.9 (33-101)	6.0-11.9 (102-204)	>12.0 (204)
Cardiovascular	MAP ≥70 mm Hg	MAP <70 mm Hg	Dopamine <5 or dobutamine (any dose)[b]	Dopamine 5.1-15 or epinephrine ≤0.1 or norepinephrine ≤0.1[b]	Dopamine >15 or epinephrine >0.1 or norepinephrine >0.1[b]
Central nervous system					
Glasgow Coma Scale score[c]	15	13-14	10-12	6-9	<6
Renal					
Creatinine, mg/dL (μmol/L)	<1.2 (110)	1.2-1.9 (110-170)	2.0-3.4 (171-299)	3.5-4.9 (300-440)	>5.0 (440)
Urine output, mL/d				<500	<200

Abbreviations: FIO_2, fraction of inspired oxygen; MAP, mean arterial pressure; PaO_2, partial pressure of oxygen.

[a] Adapted from Vincent et al.[27]

[b] Catecholamine doses are given as μg/kg/min for at least 1 hour.

[c] Glasgow Coma Scale scores range from 3-15; higher score indicates better neurological function.

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Unspecified Diagnoses Lower Severity

- Total Glasgow Score without the individual scores: No associated severity
- Shock unspecified: Only a CC unless documentation is present as to cause
- Non-Pressure Ulcer of Lower Limb: Currently listed as a CC when completely unspecified (while “other specified ulcer” of foot is not a CC). Will it stay this way?
- Currently all fractures of growth plates are a CC and do not require the Salter-Harris. Will it stay that way?

CDI should carefully review the CC/MCC list and/or codes in order to gain a greater appreciation for terms which may be in the record but which do not carry any additional severity weight due to lacking further specificity.

Coding Clinic

Glascow Coma Scale

First Quarter, 2014, Page 19

Question: ICD-10-CM provides codes to identify the Glasgow coma scale (GCS) score. When the patient presents with a traumatic brain injury (TBI), these codes are used in conjunction with the specific codes describing the TBI. If the emergency medical technician (EMT) documents the patient’s initial GCS score in the field, can the EMT’s documentation be used? Coders are concerned that there is no official advice or guideline that allows use of nonphysician documentation for the Glasgow coma scores. These scores are typically documented by personnel other than physicians. What documentation can be used for determining the ICD-10-CM Glasgow coma score code?

Answer: It would be appropriate to use the pre-hospital report containing the EMT’s documentation, and other nonphysician documentation to determine the Glasgow coma score

Coding Guideline: Coma

Coma Scale I.C.18.e

- The coma scale (R40.2-) can be used in conjunction with traumatic brain codes, **acute cerebrovascular disease** or **sequelae of cerebrovascular disease** codes.

Enhancing Query Templates

Include timeframe in days for past MI

Persistent A-Fib: Facility will need to define this until CMS addresses

Metabolic Encephalopathy to include Liver Failure as a possible cause

Fragility fractures in the presence of Osteoporosis and/or Cancer: Linkage is key

Glasgow Coma Scale reminder: Individual scores count

Gustilo Anderson Classification: A hard stop in billing

Asthma severity and chronicity (intermittent/persistent; mild/moderate/severe): better data = better management

Enhancing Query Templates (cont.)

COPD with Acute Lower Respiratory Tract Infection when Pneumonia not clinically justified: An often-missed CC

Specific Site of CVA and MI: Attending needs to bring the MRI or cath findings forward.

Non-Pressure Ulcers – Site and wound character; can a wound specialist's documentation count?

Diabetic manifestations

- PVD Specificity/ Diabetes with Neuro Manifestations/ Diabetic Osteomyelitis: Now even more of an issue than it was in ICD-9
  - Oral Manifestations, Skin Manifestations, Arthropathy Manifestations

Acute Infective Psychosis or Psychiatric Delirium on Chronic Dementia (not related to a medical problem) = Now a CC – F05

Increasing Clinical Relevance to Reduce Query Fatigue

Avoid if possible – Single Indicator Queries

- Malnutrition based solely on a BMI or albumin level
- CHF based only on Lasix
- Respiratory Failure based solely on a Pulse Ox
- Stroke based only on the duration of symptoms
- Ileus based solely on lack of bowel movement
- Encephalopathy based solely on confusion
- Renal Failure based solely on a creatinine level
- Sepsis based solely on fever and WBC
- ABLA based only on an H&H

•Image Reference: wizdata / Shutterstock

Avoiding Single Indicator Queries

So you have a Low BMI?

- What are the risk factors?
  - Acute or chronic systemic illness disease state
- What are the indicators?
  - Aspen criteria
- What are the labs telling you?
  - H&H, BUN, electrolytes, vitamin deficiency
- What is the treatment?
  - Is there any work up or treatment?

Avoiding Single Indicator Queries

So you have a patient on Lasix?

- Have you ruled out renal and liver disease?
- Do you have an echo?
- Is there a cardiac history?
- Is the patient currently fluid overloaded?
- What is the treatment?
  - Are they on any other cardiac meds?

Avoiding Single Indicator Queries

So you have Low Pulse Ox?

- Do we know the patient's baseline respiratory status?
- Was the patient in distress?
- Did we get ABGs?
- How quickly did they recover?
- Is this in conjunction with a principal diagnosis from the respiratory system?
- What was the P/F Ratio?

Avoiding Single Indicator Queries

So the patient did not have a return of bowel function for greater than 48 hours?

- What kind of procedure was performed?
  - NQF Standards for Bowel Surgery: Not an Ileus till > 4 days
- Was this an anesthesia or narcotic induced ileus?
  - Bowel function should probably return even faster than 48 hours for a patient without a GI procedure.
- What is the patient's mobility status?
- How quickly did they actually recover?
- What treatment did we render?
  - Continued NPO
  - NG Tube
  - Decubitus X-rays

Avoiding Single Indicator Queries

So the patient is confused?

- Was the origin of the confusion in any way psychiatric in nature?
- Was the origin of the confusion in any way due to the effects of psychoactive medications?
- Was the origin of the confusion most likely from an underlying pathophysiological condition?
- How quickly did they actually recover?
- What treatment did we render?

Avoiding Single Indicator Queries

So the patient has an elevated creatinine?

- What is the patient's baseline creatinine?
- What is the most likely origin of the renal failure?
  - Pre, Intra, or Post Renal?
- How quickly did they actually recover?
- What treatment did we render?

Avoiding Single Indicator Queries

So you have a patient with a fever and an elevated WBC?

- What is the localized infection?
- Is the patient immunocompromised in any way?
  - Cancer, chemotherapy, congenital blood disorders?
- Is the patient status post-op or trauma?
- Did the patient have the appearance of a toxic patient?
- What treatment did we render?
- How quickly did the patient recover?

Avoiding Single Indicator Queries

So you have a patient with a low H&H?

- What is the age of the patient?
- What are the chronic medical conditions of the patient?
  - Cancer, chronic anemia, vitamin deficiencies and malnutrition, blood loss from fibroids or GI lesions?
- Is the patient status post-op or trauma?
  - Did the patient receive >2l of fluids in a 12 to 24 hour period?
- What was the EBL?
- What treatment did we render?
  - Transfusion
- How quickly did the patient recover?
- How big of a H&H drop did we see?
  - >2gm? >4gm?
- How low did the HgB go?
  - Less than 10? Less than 8?

Chart Review – Case Number 1

Case Overview

H&P: 85 Year old Male patient admitted/coded as Urinary Tract Infection. 2/8 H&P Urinary tract infection and clinical asthmatic bronchitis in the context of elderly with change in mental status, increased confusion, leukocytosis (WBC 20.2, fever. Rule out Sepsis. Acute renal failure secondary to above (Note: +qSOFA and SIRS criteria) Discharge Summary: SIRS.

MCC/CC Opportunity

MCC On Record: Pneumonia

Clinical Indicators

Criteria 1: +SIRS in the Presence of known infection (Fever, leukocytosis)

Criteria 2: qSOFA: 1-Weakness, confusion and mental status change 2-Acute Renal failure (no documentation of dehydration)

Impact

	Original DRG: 689	New DRG: 871	Impact
GMLOS	4.0	5.0	+ 1.0
RW	1.0821	1.7926	+ 0.7105
$	$5,877	$9,735	+ $3,858
SOI/ROM	2/2	3/4	+ 1/2

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Chart Review – Case Number 2

Case Overview

H&P: 74 y/o female admitted with Aortic valve stenosis for surgery. Documented stage 3 ckd with baseline creatinine 1.9. During Admission patient's creatinine rose to 2.70. Patient's renal status was followed and the patients diuretics and fluid therapy were adjusted accordingly

MCC/CC Opportunity

Existing Severity/CC: Morbid Obesity

Clinical Indicators

Creatinine rise and fall from 1.9 to 2.7 during admission meets KDIGO threshold for Acute Renal Failure. Probably from over diuresis

Impact

	Original DRG: 221	New DRG: 220	Impact
GMLOS	4.8	6.5	+ 1.7
RW	4.5406	5.1074	+ 0.5668
$	$27,243	$30,644	+ $3,401
SOI/ROM	2/1	3/2	1/1

OPTUM360

Chart Review – Case Number 3

Case Overview

H&P: A 94 y/o female presented via EMS to with UTI and hypotension (Systolic in the 70's)

MCC/CC Opportunity

No Significant Comorbidities on record

Clinical Indicators

Aspen Criteria met: 1- 7.5% weight loss in 3 months (actual Loss: 8%) . 2-PO Intake les than or equal to 50% for greater than 5 days. BMI 21.77 Actual Weight Loss: 20lbs in 2 months. Additional Dx in chart include hypothyroid, failure to thrive, dehydration, hx of an MI and anemia.

Impact

	Original DRG: 690	New DRG: 689	Impact
GMLOS	3.1	4.0	+0.9
RW	0.7828	1.0821	+0.1993
$	$4,696	$6,492	$1,796
SOI/ROM	2/1	2/2	0/1

ICD-10 Induced DRG Shift. Band Ligation of Esophageal Varices

DRG 432 Cirrhosis & Alcoholic Hepatitis W MCC

Diagnosis

- ICD-9: 571.2 Alcoholic cirrhosis of liver
- ICD-9: 456.20 Esophageal varices in diseases classified elsewhere with bleeding (manifestation)

Procedure

- ICD-9: 42.33 Endoscopic excision/destruction of lesion/tissue of esophagus

Diagnosis

- ICD-10: K70.30 Alcoholic cirrhosis of liver without ascites
- ICD-10: I85.11 Secondary esophageal varices with bleeding

Procedure

- ~~**0DL38DZ: Occlusion of Lower Esophagus with Intraluminal device, via natural or artificial opening endoscopic.**~~
- **Wrong procedure code, correct DRG**

Coding Clinic

Coding Clinic: 4th Q 2013 Pg. 112

Question: A patient with hematemesis presents for esophagogastro-duodenoscopy. The patient is found to have esophageal varices, and therefore, ligation of esophageal varices was performed using bands placed via a band ligation device. What is the appropriate ICD-10-PCS body system for esophageal varices: gastrointestinal system or lower veins? In ICD-10-PCS, ligation is coded to the root operation occlusion. Therefore, if we use table "06L" for occlusion of lower veins, there is the appropriate body part and a device value for the bands (extraluminal device); however, there is no approach value for via natural or artificial opening endoscopic. However, if we use the "0DL" table for occlusion of gastrointestinal system and use "esophagus" for the body part, there is the appropriate approach value but there is no device option for the bands. What is the appropriate ICD-10-PCS code assignment for endoscopic banding of esophageal varices?

Coding Clinic

Answer: Esophageal varices are enlarged veins in the esophagus, which can spontaneously rupture and cause severe bleeding. Endoscopic banding of esophageal varices involves completely occluding blood flow and meets the definition of root operation "Occlusion." The lumen of the esophageal vein is being banded, not the esophagus. The index under ligation states "See occlusion."

Assign the following ICD-10-PCS code:

06L34CZ: Occlusion of esophageal vein with extraluminal device, percutaneous endoscopic approach.

The ICD-10-PCS tables currently do not use approaches containing the phrase "via natural or artificial opening" for body part values in the cardiovascular body systems. The use of this approach for blood vessel body parts could change over time if requests for additional codes are made through the ICD-10-PCS Coordination and Maintenance process

ICD-10 Induced DRG Shift. Band Ligation of Esophageal Varices

DRG 981 Extensive O.R. Procedure Unrelated to Principal Diagnosis with MCC

Diagnosis

- ICD-10: K70.30 Alcoholic cirrhosis of liver without ascites
- ICD-10: I85.11 Secondary esophageal varices with bleeding

Procedure

- 06L34CZ: Occlusion of Esophageal Vein with Extraluminal Device, Percutaneous Endoscopic Approach

Result: Correct Procedure Code - Wrong DRG

New Code Proposals. ICD 10 Coordination and Maintenance Committee Diagnosis Agenda

September 22-23 2015

- Anemia
- Asthma Levels with Uncomplicated/Controlled specificity
- Left Ventricular/Right Ventricular designation in the CHF codes
- HFrEF and HFpEF in the indexing
- High Output Heart Failure
- Intestinal Obstructions specified as Incomplete/Complete

March 9-10 2016

- Hepatic Encephalopathy
- MI Type 1 Through 5
- DMII with DKA
- Zika Virus
- C.Diff Recurrent vs Not Recurrent
- Non-Pressure Ulcers with and without necrosis of deepest level involved
- Non Healing and Slow Healing Wounds

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Q&A

Submit a question: Go to the chat pod located in the lower left corner of your screen. Type your question in the text box then click the "Send" button.