

**INGHAM**  
**R E G I O N A L**  
**MEDICAL CENTER**

**DOCUMENTATION TIPS  
FOR HEALTH CARE  
PROVIDERS**

August 2002

1

The explanations, examples, and references depicted in this handbook are intended to increase the healthcare provider's knowledge of how coding is contingent upon precise and complete clinical documentation. The goal of this handbook is to achieve accuracy in coding and DRG selection, which among other things assures correct payment for services.

If you have any comments, suggestions, or corrections, or if you have questions about correct documentation and coding, contact Sandra Oprsal, Coding Supervisor, at 334-2859

## TABLE OF CONTENTS

I. DEFINITIONS	1
II. GENERAL DOCUMENTATION ISSUES	3
CMS Requirements	3
Coder Limitations	4
Rules of Thumb	5
Most Commonly Missed CC's	6
III. SPECIFIC DOCUMENTATION ISSUES	8
Abdominal Pain	8
Acute MI Complications	9
Anemia	11
Angina	12
Atrial Fibrillation	13
Chest Pain	14
Chronic Conditions	15
CVA or TIA	16
Dehydration	17
Diabetes	18
Dizziness	19
DVT or Thrombophlebitis	20
Falls	21
Hypertension	22
Laceration of Skin Repair	23
Lesion Removal	24
Malnutrition	25
Mental Status Changes	26
Pathologic Fractures	27
Pneumonia	28
Pulmonary Edema	29
Renal Failure	30

Table of Contents (Continued)

Respiratory Failure	31
Sepsis	32
Surgical Comorbidities	33
Syncope	36
UTI/UTI with Sepsis/Urosepsis	37
Weakness	38
Wound Ulcers/Cellulitis	39
Wound Debridement (Excisional vs. Non-Excisional)	40

## I. DEFINITIONS

**CMS** (Centers for Medicare and Medicaid Services)– The organization that controls financing of, and payments under, the Medicare program. Previously known as HCFA.

**DRG** (Diagnosis Related Group) – The grouping of ICD-9-CM diagnosis and procedure codes into approximately 500 medical and surgical categories. Theoretically, the conditions and/or procedures grouped into each DRG have similar length of stay and resource use patterns.

**APR-DRG** (All Patient Refined DRG) – a patient classification system providing severity-adjustment for resource use/length-of-stay and mortality risk.

**Relative Weight** – An assigned weight that is intended to reflect the relative resource consumption associated with each DRG. The higher the Relative Weight the greater the payment to the hospital.

**Blended Rate** – The amount of money that a hospital will be paid under the Medicare program for an inpatient case for a DRG with a Relative Weight of 1.000. It is based on national average hospital costs, geographic location (local labor costs), percentage of indigent population served, training programs, etc.

**Hospital Payment** – This is calculated by multiplying the relative weight of the DRG by the blended rate assigned to the hospital.

**Principal Diagnosis** – That condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care. The principal diagnosis is the *underlying cause* of the patient's presenting signs and symptoms.

**Comorbidity** – A pre-existing condition that can be the cause an increased length of stay or increased resources. When paired with particular principal diagnoses, certain comorbid conditions will change the DRG assignment.

**Complication** – A condition arising during the hospital stay that can prolong the hospital stay or require increased resources. MOST OF THESE DO NOT IMPLY ADVERSE CONSEQUENCES OF CARE DELIVERY.

**cc** – Abbreviation for “complications and/or comorbidities.” The list of DRG's has many pairs, one with cc, and the other without cc. There can be large differences in payments to hospitals based on the presence of cc's.

**Other Diagnoses** – (including comorbidities and complications) - For reporting/coding purposes, the definition for “other diagnoses” is interpreted as additional conditions that affect patient care in terms of requiring:

- Clinical evaluation
- Extended length of hospital stay
- Therapeutic treatment
- Increased nursing care and/or monitoring
- Diagnostic procedures

## II. GENERAL DOCUMENTATION ISSUES

CMS mandates that all medical conditions evaluated, monitored or treated should be reported/coded. DRG and code assignments must be consistent with AHA (American Hospital Association) and CMS (Centers for Medicare and Medicaid Services) regulations. Presently, Medicare has a program in place to help assure accurate DRG assignment referred to as PEPP (Payment Error Prevention Program). Ingham Regional Medical Center conducts quarterly internal and external coding and DRG assignment audits with the same goal in mind.

Optimal Coding/DRG Assignment has several implications for physicians and hospitals:

- 1) Severity of illness, length of stay, and risk of mortality data will be supported by complete and accurate coding and DRG assignment.
- 2) Hospital reimbursement can be dramatically impacted by "minor" DRG changes.
- 3) The Office of the Inspector General (OIG) has begun to audit physicians whose procedural codes show a discrepancy from hospital codes.

## LIMITATIONS ON CODERS

Certified coders are “limited” by (1) the quality of documentation in the hospital record (e.g., H&P, Progress notes, discharge instructions, discharge summary), (2) the coding “game rules” mandated by the government, and (3) their own personal error rate (less than 5% at IRMC). Coders are not allowed to “interpret.”

Simply reading in the progress notes that “hemoglobin=5.0” cannot be coded as anemia unless the physician states anemia in the record. Pathology, radiology, or laboratory reports present in the chart, but not reviewed and interpreted in the progress notes essentially “don’t exist” for coding purposes.

Inconsistent documentation (e.g., noted in the discharge summary but not the H & P or progress notes) may also lead to suboptimal DRG determination. “Game rules” are abundant. For example, “Urosepsis” cannot be coded as UTI with sepsis but must be coded as UTI (a reimbursement difference of \$3,820). The physician must instead document “The patient has UTI with sepsis.”

## RULES OF THUMB

The following rules of thumb may be helpful:

- 1) Write in the progress notes all significant test results and interpret the results. Document "The patient is hyponatremic with a NA of 120", instead of "Na=120." Document "The patient has acute blood loss anemia: Hg went from 14 down to 7, given 3 units packed cells, now 10", instead of just "Hg 7".
- 2) Attempt to state the *most likely etiology* of symptoms: "The abdominal pain is possibly/probably due to pancreatitis." "The chest pain is most likely due to reflux esophagitis."
- 3) Avoid "R/O" Terminology. For the "coding game rules," R/O is meaningless.
- 4) If unable to obtain a documenting test (e.g. sputum sample for culture), state what you are treating based on the clinical picture (i.e. "Patient most likely has G- pneumonia as immunosuppressed and living in a NH. G-Rx given. Unable to get adequate sputum sample.")
- 5) Establish cause and effect (i.e. peripheral vascular disease due to diabetes, anemia secondary to acute blood loss, UTI secondary to indwelling urinary catheter, fracture due to osteoporosis).
- 6) Make sure the discharge summary accurately reflects the preponderance of evidence in the record. Auditors will make DRG changes when they see understated discharge diagnoses.

**EXAMPLES OF THE MOST COMMONLY MISSED CC'S ARE:**

- acute myocardial infarction
- alcoholism, acute/chronic
- agranulocytosis
- anemia due to blood loss, acute/chronic
- angina pectoris
- aortic and mitral valve disorder
- atrial fibrillation/flutter
- atelectasis
- cardiogenic shock
- cardiomyopathy
- cellulitis
- congestive heart failure (CHF)
- chronic obstructive pulmonary disease (COPD)
- decubitus ulcer
- dehydration
- diabetes mellitus, insulin dependent, type I
- emphysema
- hematuria
- hematemesis
- hydronephrosis
- hypertensive heart disease with CHF
- hypertensive renal disease with renal failure
- hyponatremia
- malnutrition
- melena
- paralytic ileus
- paroxysmal supraventricular tachycardia
- pneumothorax
- postinflammatory pulmonary fibrosis
- renal failure

**EXAMPLES OF THE MOST COMMONLY MISSED CC'S  
(continued):**

- respiratory failure
- seizure disorder/ convulsions/ epilepsy
- uncontrolled DM
- urinary retention
- urinary tract infection
- written diagnosis interpreted from lab, x-ray report

### III. SPECIFIC DOCUMENTATION ISSUES

#### ABDOMINAL PAIN

Abdominal pain is only a symptom. The necessity for use of multiple medical resources and true assessment of severity of illness is better documented by establishing the MOST LIKELY etiology: For example:

- Peptic ulcer disease
- GE reflux
- Cirrhosis
- Gastritis
- Duodenitis
- Cholecystitis
- Pancreatitis
- Hepatitis
- Hepatic tumor
- Obstruction
- Ileus
- Diverticulitis

It is imperative that you document your suspicions as to the underlying cause of abdominal pain to better reflect your efforts on behalf of your patient. If uncertain, it is appropriate to use terms such as “probably” or “possibly.”

## ACUTE MYOCARDIAL INFARCTION COMPLICATIONS

While an acute MI is significant by itself, the occurrence of comorbid conditions and certain post-infarction events further impacts the severity of illness. It is crucial to document the presence of these cardiovascular comorbidities when they occur to recognize your efforts for these severely ill patients.

Common comorbidities and post infarction cardiovascular complications necessitating extra LOS include:

- New or exacerbated CHF
- Arrhythmias (specify type)
- Hypotension (specify cause)
- Intracranial hemorrhage
- Cardiogenic shock
- Cardiac arrest
- Bundle branch block
- Post infarction EKG changes  
(*Document change in progress notes*)
- Postmyocardial infarction syndrome
- Atelectasis/ pulmonary collapse
- Respiratory insufficiency or failure
- CVA
- Decubitus ulcer
- Acute renal failure
- Pulmonary embolism
- Pneumonia
- Atrioventricular block
- Aneurysm of heart/aorta

	<u>LOS</u>	<u>Relative Wt.</u>	<u>Payment</u>
DRG 121 <i>Acute MI with complications</i>	6.9	1.5787	\$8,932.28
DRG 122 <i>Acute MI without complications</i>	3.9	1.0241	\$5,794.36

## ANEMIAS

It is important to document the presumed etiology of a drop in hemoglobin. Common etiologies are:

- Acute or chronic blood loss
- Nutritional difficulties (Iron, B12, folate)
- Renal disease
- Malignancy and myelodysplasia
- Alcohol abuse
- Chemotherapy or radiation therapy

Documenting the presumed cause of the anemia insures that the physician receives the appropriate credit for all his/her efforts on behalf of patient. Anemia may also be a comorbid condition and attests to the fact that a physician is caring for a sicker patient, especially in cases of post-operative blood loss anemia.

For example:

	<u>LOS</u>	<u>Relative Wt.</u>	<u>Payment</u>
DRG 148	13.1	3.5332	\$19,990.85
<i>Small &amp; large bowel procedures with cc</i>			
DRG 149	6.7	1.5063	\$8,522.65
<i>Small &amp; large bowel procedures without cc</i>			

## ANGINA

The clinical term “angina” is a complex symptom. The patient’s true severity of illness is best explained by establishing the most likely etiology:

- Coronary artery disease (stable or unstable angina)
- Coronary vasospasm (Prinzmetal’s)
- Arrhythmia
- Valvular heart disease
- Hypoxia
- Anemia

	<u>LOS</u>	<u>Relative Wt.</u>	<u>Payment</u>
DRG 140 <i>Angina pectoris</i>	2.7	0.5335	\$3,018.54
DRG 132 <i>Atherosclerosis with cc</i>	3.1	0.6473	\$3,662.42

## **ATRIAL FIBRILLATION**

Often a probable cause for atrial fibrillation can be identified. Documenting the etiology will most accurately reflect the patient's severity of illness.

Possible etiologies are:

- CHF
- Valvular heart disease
- Electrolyte abnormality
- Hyperthyroidism
- Chronic lung disease
- Pulmonary hypertension

## CHEST PAIN

Chest pain is only a symptom. The patient's true severity of illness and need for resources is best documented by establishing the most likely etiology:

- Coronary artery disease
- Pneumonia
- Coronary vasospasm
- Pulmonary embolism
- GERD
- Pleurisy/pericarditis
- Chest wall pain
- Anxiety
- Costochondritis

It is appropriate to document the "possible," "probable," or "most likely" diagnosis when the diagnosis cannot be established beyond a shadow of a doubt. Avoid documenting "non-cardiac" chest pain, as the code assignment is simply "other chest pain".

	<u>LOS</u>	<u>Relative Wt.</u>	<u>Payment</u>
DRG 143 <i>Chest pain</i>	2.1	0.5191	\$2,937.07
DRG 183 <i>Esophagitis, GERD</i>	3.0	0.5568	\$3,150.37
DRG 102 <i>Costochondritis</i>	2.7	0.5207	\$2,946.12
DRG 425 <i>Anxiety</i>	4.2	0.6789	\$3,841.22

## **CHRONIC CONDITION**

It is important to document chronic conditions as they impact resource utilization. Common chronic disorders include:

- Angina (stable or unstable)
- Atrial fibrillation
- Aplastic anemia
- Renal failure (acute/chronic)
- COPD
- CHF
- Pulmonary fibrosis
- Drug abuse/dependence
- Cirrhosis
- Diabetes (specify Type I/II)

## CVA or TIA?

Astute neurologic exam and CT scanning are important in clarifying CVA vs. TIA. Neurologic consultation is encouraged. Generally, the symptoms of a CVA, (such as weakness of a limb, paralysis, dysphasia, dysphagia), do not resolve within 24 hours of onset. Note differences in the two DRG's:

	<u>LOS</u>	<u>Relative Wt.</u>	<u>Payment</u>
DRG 014 CVA	6.1	1.1655	\$6,594.40
DRG 015 TIA	3.7	0.7349	\$4,158.06

**When documenting for a CVA, documentation of “infarct” and the cause of the CVA, such as occlusion of carotid arteries or cerebral arteries, thrombus, or embolism also has a significant coding/reporting impact.**

## TIA's

TIA's are symptoms of many disease entities such as atrial fibrillation with embolism, carotid artery stenosis/occlusion, arrhythmia, etc. It is important to document the most likely cause. If a clinical diagnosis of CVA is more appropriate than TIA, it should be documented.

## DEHYDRATION

Dehydration is often a comorbid condition associated with another condition, such as gastroenteritis. Payors expect excellent documentation to establish this diagnosis.

Documenting all treatment and symptoms of dehydration assist in the acceptance of this diagnosis by third party payors, such as:

- Tachycardia
- Hypernatremia
- Dry mucous membranes
- Orthostasis
- Increased urine specific gravity

Simply stating that there is dehydration, based on history, will not qualify. Payors are looking for a treatment regimen that supports the dehydration diagnosis, such as "500 cc bolus and IV hydration at 250 cc/hr" instead of merely "K/O or IV hydration 75 cc/hr."

**DIABETES**

Outside reviewers look at pathophysiology to assess severity of illness/utilization of resources. Type I diabetics suffer from a deficit of insulin; Type II diabetics exhibit insulin resistance. Both types occur at any age and both may require insulin. It is much clearer to document diabetes as being "Type I" or "Type II" than to say "IDDM" or "NIDDM".

To qualify as a "cc," a patient must have Type I diabetes or have blood sugars "out of control". It is imperative to document these conditions to receive credit for their more complex care. When sugars are elevated, the term "out of control" is the proper jargon, not "poorly controlled."

Coders cannot assume a cause and effect relationship between diabetes and renal, ophthalmic, neurological, or peripheral circulatory manifestations unless the physician has indicated this in the patient's record. If a condition is not specified as being due to diabetes, then the condition and the diabetes are coded separately.

A comorbidity of diabetes specified as being Type I is a diagnosis that impacts the DRG when paired with certain principal diagnoses. Diabetes Type II as a secondary diagnosis usually does not affect the DRG assignment.

	<u>LOS</u>	<u>Relative Wt.</u>	<u>Payment</u>
DRG 090	4.3	0.6344	\$3,589.44
<i>Simple pneumonia <u>without a cc</u> such as DM Type I</i>			
DRG 089	6.3	1.0601	\$5,998.05
<i>Simple pneumonia <u>with a cc</u> such as DM Type I</i>			

## **DIZZINESS**

Dizziness is another symptom underlying many disease entities, each of which has varying levels of disability/care requirements resulting in different resource intensity.

It is important that the medical record reflects the most likely cause of the dizziness to indicate the severity of the patient's condition and your efforts on behalf of the patient.

## DVT AND THROMBOPHLEBITIS

While deep vein thrombosis (DVT) and thrombophlebitis are inevitably linked in clinicians' minds, coding guidelines differentiate between the two conditions.

For patients admitted for evaluation and treatment of DVT with signs and symptoms of thrombophlebitis (redness, swelling, tenderness, heat or pain), it is important to document both conditions. In these cases, you cannot simply write DVT; you must specify thrombophlebitis. Thereby, you will more accurately describe the patient's severity of illness and receive appropriate credit for the care provided.

	<u>LOS</u>	<u>Relative Wt.</u>	<u>Payment</u>
DRG 131 <i>Thrombosis of the venous system without cc</i>	4.5	0.5725	\$3,239.21
DRG 128 <i>Deep vein thrombophlebitis</i>	5.9	0.7320	\$4,141.66

## FALLS

Falling very often precipitates a hospital admission. Although many falls are "accidental," a significant number are the result of an underlying pathologic process. It is critical that the suspected pathophysiology be documented. Some causes might be:

- TIA
- CVA
- Cardiac arrhythmias
- Dehydration/orthostasis
- Anemia (acute/chronic blood loss)
- Labyrinthitis

It is also important to note the presence of any sequelae of the fall, such as fractures, contusions, or lacerations.

## HYPERTENSION

It is important to document the terms “malignant”, or “accelerated” when applicable, rather than “hypertensive urgency”, “uncontrolled”, or “severe”. There is a different code assignment for malignant/accelerated, benign, and unspecified hypertension. Despite obvious differences in clinical management, the true activity of these patients is best illustrated by noting the presence of any of the following:

- Hypertensive encephalopathy (*headache, nausea, vomiting, visual change, or neurologic symptoms*)
- CHF
- Angina
- Acute renal failure
- Stroke
- Renovascular disease

When hypertension occurs with renal disease, coders are allowed to assign the combination code for hypertensive renal failure. However, the cause and effect relationship between other hypertensive conditions must be specifically stated by the physician; e.g., “hypertensive heart disease”.

When hypertension and renal artery stenosis coexist, the documentation should state whether the hypertension is secondary to the renovascular disease, or is a primary hypertension. When hypertension is present in a pregnant patient, the documentation should reflect whether the hypertension is pregnancy induced or pre-dates the pregnancy, and whether or not the patient has pre-eclampsia or eclampsia.

## LACERATION REPAIR OF SKIN

CPT code assignment for laceration repair of skin and subcutaneous tissue requires documentation of the length of the repair, the site(s), and the type of repair.

The wound should be measured and recorded in centimeters, whether curved, angular, or stellate.

The type of repair is classified as simple, intermediate, or complex. A simple repair is used when the wound is superficial; e.g. involving primarily epidermis or dermis, or subcutaneous tissues without significant involvement of deeper structures, and requires simple one layer closure.

An intermediate repair includes wounds that require layered closure of one or more of the deeper layers of subcutaneous tissue AND superficial (non-muscle) fascia, in addition to the skin (epidermal and dermal) closure.

Complex repair includes the repair of wounds requiring more than layered closure, such as scar revision, extensive debridement, (e.g., traumatic lacerations or avulsions), or extensive undermining.

There are additional code assignments for adjacent tissue transfer or rearrangement (e.g. Z-plasty, rotation flap, advancement flap), free skin grafts (e.g. pinch, split thickness, full thickness, Alloderm), and flap grafts (e.g. tubed pedicle).

## **LESION REMOVAL**

CPT code assignment for lesion removal requires documentation of the size and location of the lesion(s). When a lesion is an irregular shape, the largest dimension determines the code assignment. Skin margins removed surrounding the lesion are not included in the lesion removal code, thus they should be reported as a separate dimension.

Each lesion removed must be documented separately, since the removal of multiple lesions requires additional time and effort, and is reimbursed accordingly.

When the closure requires intermediate or complex repair, the additional work should be documented.

## **MALNUTRITION**

Many patients suffer from malnutrition, especially the young and elderly. Documenting the presence of malnutrition when clinically suspected will better reflect their prolonged care needs. Documentation from the Dietician is not sufficient for reporting/coding malnutrition. One acceptable example of parameters when considering malnutrition:

**Severe:**            20% below usual weight  
                         Serum Albumin <2.5 gm/dl.  
                         Overt signs of muscle wasting are evident

**Moderate:**        Two of the following are met:  
                         Serum albumin 2.5-2.9  
                         Weight is 70-79% IBW  
                         Weight is 75-84% of Usual Weight

**Mild:**              Two of the following must be met:  
                         Serum albumin 2.9-3.4  
                         Weight is 80-89% IBW  
                         Weight is 85-95% usual weight

The presence of nutritional disorders such as osteoporosis, osteomalacia, and anemias are strong indicators of the presence of malnutrition.

## MENTAL STATUS CHANGES

The observation of mental status changes is frequent especially in the elderly. While the exact etiology may be difficult to assess, noting the most likely cause will better attest to the patient's needs. Some common causes of alterations in mental status are:

- Sepsis
- CVA
- Diffuse cardiovascular disease
- Myocardial infarction
- Dehydration
- Electrolyte abnormalities
- Neuro-psychiatric diseases (Alzheimer's, Parkinson's)
- Medication effects (accidental, intended)

## PATHOLOGIC FRACTURES

Fracture in any bone resulting from an underlying disease process should be considered a pathologic fracture.

Pathological fractures may occur either spontaneously or following minor trauma. In general, if a fall would not have caused a fracture in a "normal" person, the fracture should be designated as pathologic. Some causes of pathologic fracture are:

- Osteoporosis
- Multiple myeloma
- Radiation therapy
- Primary or metastatic tumors
- Chronic steroid use

	<u>LOS</u>	<u>Relative Wt.</u>	<u>Payment</u>
DRG 236 <i>Non-pathologic hip fracture</i>	4.9	0.6889	\$3,897.80
DRG 239 <i>Pathologic hip fracture</i>	6.7	1.0032	\$5,676.11

**PNEUMONIA**

Proper documentation/coding of pneumonia includes the type or etiology of the pneumonia. Frequently, a satisfactory sputum sample cannot be obtained. In these cases you must document your clinical impression of the bacterial or viral type of the pneumonia, such as gram negative, anaerobic, or Streptococcus pneumoniae. Also, document aspiration pneumonia when aspiration is the known or suspected etiology. Only document “unknown” type of pneumonia when the patient’s history and risk factors do not indicate a specific type or etiology. Although the term “community acquired” may have significance to clinicians, it does not indicate the causative organism, and has to be assigned the “unspecified” pneumonia code.

If a satisfactory sputum culture has been obtained, it is a must that the progress notes acknowledge the sputum report. Coders cannot take a gram-negative culture report and interpret that to mean gram-negative pneumonia. The physician must reiterate this in the progress notes.

The DRG assignment for pneumonia is divided between simple pneumonia (viral, pneumococcal, H. influenzae, streptococcal, and unspecified) and complex pneumonia (Klebsiella pneumoniae, Pseudomonas, Staphylococcus, other gram negative bacteria, and aspiration).

	<u>LOS</u>	<u>Relative Wt.</u>	<u>Payment</u>
DRG 089 <i>Simple pneumonia with cc</i>	6.3	1.0601	\$5,990.05
DRG 079 <i>Aspiration, G-pneumonia</i>	9.3	1.7094	\$9,671.79

## **PULMONARY EDEMA**

This finding requires documentation as to the most likely etiology to best support your efforts for these severely ill patients. Some causes are:

- Renal failure with volume overload
- CHF
- Adult respiratory distress syndrome (ARDS)
- Cirrhosis
- Drug induced

## RENAL FAILURE

Patients with a variety of conditions may exhibit an abrupt decline in renal function consistent with renal failure (ARF). It is important to specify whether the failure is "acute" vs. "chronic", or "acute or chronic" failure. It is also important to distinguish between renal "insufficiency" and "failure". The clinical term "renal insufficiency" has a different code and DRG assignment than "renal failure" and should not be used interchangeably. Corroborating symptoms or labs are helpful: increased creatinine, decreased creatinine, creatinine clearance, acidosis, hyperphosphatemia, anemia, nausea/vomiting, pruritis.

Patients who have CRF often are admitted with both CHF and renal failure. For correct DRG assignment, it is important to distinguish which condition was the principal reason for admission, or if both were equal reasons for admission. DRG assignment will also change if the renal failure is documented to be a manifestation of diabetes.

	<u>LOS</u>	<u>Relative Wt.</u>	<u>Payment</u>
DRG 331 <i>Diabetes with renal manifestation</i>	6.0	1.0640	\$6,020.11
DRG 316 <i>Renal failure</i>	7.3	1.3745	\$7,776.92
DRG 331 <i>Renal insufficiency</i>	6.0	1.0640	\$6,020.11
DRG 127 <i>CHF</i>	5.6	1.0103	\$5,716.28

## RESPIRATORY FAILURE

The diagnosis of respiratory failure is usually based on alterations in arterial blood gases, however ABGs are not required to clinically diagnose acute respiratory failure. Although some cases of respiratory failure must be managed with mechanical ventilating support, the absence of mechanical ventilation does not preclude a diagnosis of respiratory failure. Respiratory "failure" and respiratory "insufficiency" have different code and DRG assignments, thus the terms should not be used interchangeably.

	<u>LOS</u>	<u>Relative Wt.</u>	<u>Payment</u>
DRG 087	6.9	1.4282	\$8,080.76
<i>Respiratory failure</i>			

DRG 099	3.3	0.6964	\$3,940.23
<i>Respiratory insufficiency with cc</i>			

It is important to document the underlying cause of the respiratory failure, because coding guidelines require that if the underlying cause is a respiratory condition, such as pneumonia, or COPD, then the respiratory failure be sequenced as the principal diagnosis. However, if the underlying cause is an acute non-respiratory condition, such as CHF, then the acute non-respiratory condition is sequenced as the principal diagnosis.

	<u>LOS</u>	<u>Relative Wt.</u>	<u>Payment</u>
DRG 087	6.9	1.4282	\$8,080.76
<i>Respiratory failure due to COPD</i>			

DRG 127	5.6	1.0103	\$5,716.28
<i>Respiratory failure due to CHF</i>			

## **SEPSIS**

Sepsis is a clinical syndrome. It is often suspected when there is a mental status change, leukocytosis, tachycardia, tachypnea, hypotension, fever or chills. Bacteremia and sepsis are different entities.

A diagnosis of sepsis does not require positive blood cultures although that may be the case. Likewise, not all cases of bacteremia have sepsis.

Sepsis results from a systemic inflammatory response to infection, and need not be associated with bacteremia. See also the section on "urosepsis".

## SURGICAL COMORBIDITIES AND COMPLICATIONS

CMS has developed a list of diagnoses that are recognized as conditions that make patient management more difficult. Documenting the presence of such conditions only depicts on your profile how ill your patients are. Important conditions to document are:

- Acidosis
- Acute blood loss anemia
- Angina
- Atrial fibrillation
- Atelectasis
- Chronic blood loss anemia
- CHF or history of CHF
- COPD or history of COPD
- Diabetes mellitus (*Type 1 or "uncontrolled"*)
- Dehydration
- Fecal impaction
- Fever post-op (*even if expected – document if related to the surgery, with your evaluation and treatment*)
- Hematuria
- Ileus
- Malnutrition
- Pneumonia
- Pathologic fracture
- Phlebitis (*IV site or leg*)
- Respiratory failure
- Sepsis

Examples of differences resulting from the documentation of surgical comorbidities/ complications:

	<u>LOS</u>	<u>Relative Wt.</u>	<u>Payment</u>
DRG 146 <i>Rectal resection with cc</i>	10.9	2.7764	\$15,708.87
DRG 147 <i>Rectal resection without cc</i>	6.7	1.5993	\$9,048.84
DRG 148 <i>Colectomy with cc</i>	13.1	3.5332	\$19,990.85
DRG 149 <i>Colectomy without cc</i>	6.7	1.5063	\$8,522.65
DRG 154 <i>Stomach, esophageal, duodenal procedure with cc</i>	14.7	4.3519	\$24,623.05
DRG 155 <i>Stomach, esophageal, duodenal procedure w/o cc</i>	4.5	1.3273	\$7,509.86
DRG 164 <i>Appendectomy with cc</i>	9.0	2.3960	\$13,556.57
DRG 165 <i>Appendectomy without cc</i>	5.0	1.2904	\$7,301.08
DRG 195 <i>Cholecystectomy with CBD exploration with cc</i>	10.9	3.0863	\$17,462.29
DRG 196 <i>Cholecystectomy with CBD exploration w/o cc</i>	6.0	1.6111	\$9,115.60

Examples of differences resulting from the documentation  
of surgical comorbidities (continued):

	<u>LOS</u>	<u>Relative Wt.</u>	<u>Payment</u>
DRG 334 <i>Radical prostatectomy with cc</i>	5.0	1.5177	\$8,587.15
DRG 335 <i>Radical prostatectomy w/o cc</i>	3.3	1.1047	\$6,250.39
DRG 370 <i>Cesarean section with cc</i>	6.1	1.0572	\$5,982.64
DRG 371 <i>Cesarean section without cc</i>	3.7	0.6845	\$3,872.90
DRG 497 <i>Spinal fusion with cc</i>	6.9	3.2324	\$18,288.92
DRG 498 <i>Spinal fusion without cc</i>	4.3	2.3026	\$13,028.11

## **SYNCOPE**

Syncope is another symptom reflecting many disease entities, each of which has different levels of severity of illness/care requirements. Often the diagnosis after testing is not clear-cut, but it is appropriate to state the most likely cause, such as:

- Arrhythmia
- TIA
- Seizure
- Orthostatic hypotension
- Adverse effect of medication

## UTI/UTI WITH SEPSIS/UROSEPSIS

Outside reviewers interpret “urosepsis” to mean simple UTI. Therefore, do not use the term urosepsis in a patient who has sepsis and a UTI. Please see the sepsis section. Sepsis increases the severity illness/LOS/reimbursement.

	<u>LOS</u>	<u>Relative Wt.</u>	<u>Payment</u>
DRG 320 <i>UTI with cc</i>	5.6	0.8593	\$4,861.92
DRG 416 <i>Sepsis with or without UTI</i>	8.1	1.6226	\$9,180.67

If the patient has only a UTI, document only “UTI.”

If the patient has UTI with sepsis, document “UTI with sepsis.”

## **WEAKNESS**

Weakness is a symptom. While the exact etiology may be difficult to assess, noting the most likely cause will better reflect the patient's needs. Some causes might be:

- Anemia
- CHF
- CVA
- Dehydration
- Electrolyte abnormalities
- Myocardial infarction
- Hypothyroidism
- Medication effect

## INFECTED WOUND ULCER/CELLULITIS

A significant difference exists in the care needs of a patient when a wound ulcer becomes infected vs. simple cellulitis with no wound ulcer. Therefore, it is critical to document the presence of infected wound ulcer.

It is also important to document the etiology of the skin ulcer, such as peripheral vascular disease, diabetic neuropathy, post-traumatic, etc, as the etiology may also change the code and DRG assignment.

	<u>LOS</u>	<u>Relative Wt.</u>	<u>Payment</u>
DRG 271 <i>Skin ulcer without cellulitis</i>	7.7	1.0365	\$5,864.52
DRG 278 <i>Cellulitis w/o skin ulcer or other cc</i>	4.5	0.5487	\$3,104.54
DRG 277 <i>Cellulitis with skin ulcer or other cc</i>	6.1	0.8534	\$4,828.54
DRG 130 <i>PVD with skin ulcer and cellulitis</i>	6.1	0.9379	\$5,306.64

**WOUND DEBRIDEMENT:  
EXCISIONAL VS. NON-EXCISIONAL**

Payors differentiate whether a wound debridement is "excisional" or "non-excisional". Coding and payor guidelines demand that these terms be used with a description of what instrument was used to debride (knife, scalpel, scissors, etc.) as well as what tissue was removed (skin/SQ tissue, muscle, or bone).

	<u>LOS</u>	<u>Relative Wt.</u>	<u>Payment</u>
DRG 018 <i>Diabetic neuropathy with ulcer and <u>non-excisional</u> debridement</i>	5.8	0.9744	\$5,513.16
DRG 007 <i>Diabetic neuropathy with ulcer and <u>excisional</u> debridement</i>	11.1	2.6285	\$14,872.05
DRG 271 <i>Skin ulcer w/o debridement</i>	7.7	1.0365	\$5,864.52
DRG 264 <i>Skin ulcer with <u>excisional</u> debridement w/o cc</i>	7.3	1.1079	\$6,268.50
DRG 263 <i>Skin ulcer with <u>excisional</u> debridement with cc</i>	12.3	2.0570	\$11,638.51