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CDI IN BLOOM | **acdis 2023**

MAY 8–11, 2023



Principal Diagnosis Dilemma

Vanessa Elliott, BSN, RN, CCDS

Enterprise System CDI Educator

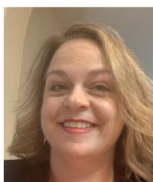
West Virginia University Medicine

Morgantown, West Virginia

hcpro

 **acdis**

Presented By



Vanessa Elliott, BSN, RN, CCDS, is an enterprise system CDI educator at WVU Medicine based in Morgantown, West Virginia. The team at WVU consists of a director, two managers, two educators, 25 inpatient staff, and two outpatient staff. She has 28 years of nursing experience and 10 years as a CDI professional. Prior to entering the CDI arena, Elliott worked in a variety of settings such as case management, utilization review, and ICU (which included neuro, CICU, and a mixed ICU setting). Elliott serves on the 2022/2023 ACDIS Leadership Council.

Learning Outcomes

- At the completion of this educational activity, the learner will be able to:
 - Identify key concepts in coding regarding signs and symptoms
 - Explain the PDF approach to a review
 - Select the opportunities within the case studies provided
 - Discuss a DRG with associated codes that can be further clarified

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Inpatient Revenue

- Inpatient revenue constitutes a significant percentage of hospitals' total patient revenues.
- Of the hospitals with the highest total patient revenues, inpatient earnings were greater for 6 of the top 10 according to Definitive Healthcare data.



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Primary Diagnoses

- What do you expect to be the number one DRG based on 2019 data?
 - 193 Simple pneumonia & pleurisy with MCC
 - 291 Heart failure & shock with MCC
 - 871 Sepsis with MCC
 - 885 Psychoses

The answer is DRG.....885



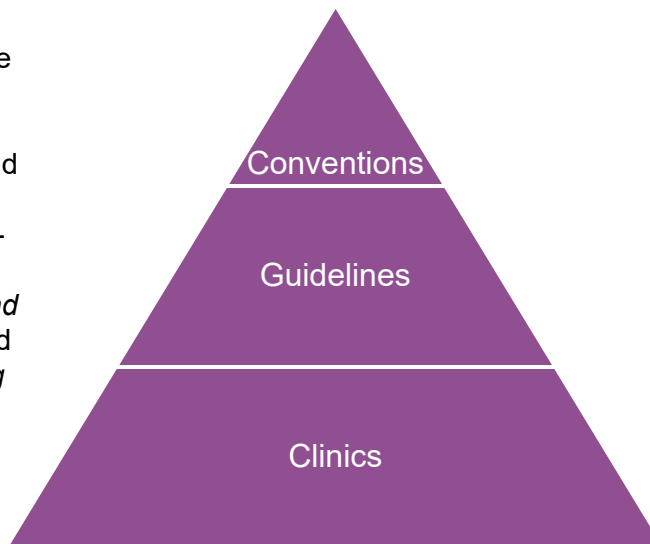
Top 10 Primary Diagnoses by DRG Code

Description	DRG Code	Est # Primary Diagnoses
PSYCHOSES	885	1,713,938
NORMAL NEWBORN	795	1,703,866
SEPTICEMIA OR SEVERE SEPSIS W/O MV 96 OR MORE HOURS W MCC	871	1,549,230
MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W/O MCC	470	1,234,651
HEART FAILURE & SHOCK W MCC	291	851,865
NEONATE W OTHER SIGNIFICANT PROBLEMS	794	598,702
ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/O MCC	392	577,784
SIMPLE PNEUMONIA & PLEURISY W MCC	193	518,828
SIMPLE PNEUMONIA & PLEURISY W CC	194	416,026
SEPTICEMIA OR SEVERE SEPSIS W/O MV 96 OR MORE HOURS W/O MCC	872	409,697

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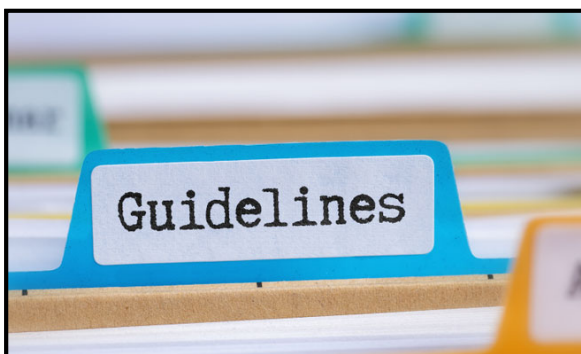
Coding Hierarchy

When there is a discrepancy between the conventions in the classification, the guidelines, and/or advice published in *Coding Clinic*, coding professionals should adhere to the **following hierarchy**:
Conventions in the ICD-10-CM and ICD-10-PCS classification take precedence over the *Official Guidelines for Coding and Reporting*, and both the classification and guidelines take precedence over *Coding Clinic* advice.



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Coding Guidelines



UHDDS

The principal diagnosis is defined as the condition established after the study to be chiefly responsible for the admission of the patient to the hospital for care. It is important that the principal diagnosis be designated correctly because its establishment is significant in cost comparisons, in care analysis, and in utilization review.

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Can Signs/Symptoms Be Coded as Principal Diagnosis?



- **There are only a few inpatient situations in which a symptom code from chapter 18 can be correctly designated as the principal diagnosis, as follows:**
- When no related condition is identified and the symptom is the reason for the encounter, a code from chapter 18 of ICD-10-CM is assigned as the principal diagnosis even though other unrelated diagnoses may be listed.
- For example, a patient is admitted with tachycardia. An electrocardiogram (EKG) does not provide any conclusive evidence of the type of tachycardia or of any underlying cardiac condition. The patient also has insulin-dependent diabetes; blood sugars are monitored daily during the hospital stay. The reason for admission is tachycardia; therefore, code R00.0, Tachycardia, unspecified, is the principal diagnosis. Since the diabetes was treated during the hospital stay, an additional code is assigned for the diabetes mellitus.

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Can Signs/Symptoms Be Coded as Principal Diagnosis?

- Other situations in which codes from chapter 18 of the ICD-10-CM manual can be appropriately used as the principal diagnosis for an inpatient admission include the following:
 - Presenting signs or symptoms are transient, and no definitive diagnosis can be made.
 - The patient is referred elsewhere for further study or treatment before a diagnosis is made.
 - A more precise diagnosis cannot be made for any other reason.
 - The symptom is treated in an outpatient setting without the additional workup required to arrive at a more definitive diagnosis.
 - Provisional diagnosis of a sign or symptom is made for a patient who fails to return for further investigation or care.
 - A residual late effect is the reason for admission, and the Alphabetic Index directs the coding professional to an alternative sequencing.

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Sign vs. Symptom

Sign	Symptom
Objective evidence of disease observed by examining physician	Subjective observation reported by patient
High blood pressure	Headache
Tachypnea	Shortness of breath
Vomiting	Nausea
Diaphoresis	Chest Pain

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What Should I Do Next?

Is there a possible known cause of symptoms?

- *Yes
- **No
- # Not sure; continue to follow the chart daily if possible

*Yes

- Send a query asking for the link to the symptoms and condition.

**No

- Continue to follow the patient for any additional information that could change your answer or conflict what has already been addressed

P-D-F Approach to Determining Principal Dx



Presenting signs and symptoms



Diagnosis that necessitates inpatient admission



Focus of treatment

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????? Principal Diagnosis ?????

Example

- Patient came into ED c/o difficulty catching breath due to increased heart rate
- Found to be in Afib with a history of Afib. Afib resolved shortly after admission with no drips needed.
- During the workup on admission, the patient was found to have bilateral infiltrates and rhonchi in bilateral lower lobes, along with O₂ sats 90-91% requiring O₂ 3L. H&P states possible pneumonia and Afib. Documentation throughout the medical record including the D/C summary says pneumonia.
- On admission, treatment began using oxygen, IV Rocephin and Zithromax



What would you choose as your principal dx?

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Definition of Etiology

- Cause, set of causes, or manner of causation of a disease or condition
- The investigation or attribution of the cause or reason for something

Example of Etiology

John has multiple deadlines in his work week but has a major presentation to a company that his VP wants to acquire as a new account. The presentation in its entirety is due Friday at 1 pm. On Monday prior to the meeting, he has only completed 50% of the work for the presentation. On Tuesday, he takes off early for a personal appointment. On Wednesday, he works on other assignments. On Thursday, he stays late to finish the presentation but realizes late that evening that he has some missing data for the presentation. When he arrives early Friday morning, the system that he needed to acquire the data from is experiencing “technical difficulties” and he is unable to access the information needed.

What would be the main contributing factor(s) that led to John not being prepared for his Friday presentation?

- A.) Personal appointments
- B.) Inability to manage priorities
- C.) Lack of planning
- D.) B & C
- E.) All of the above

Etiology

What would be the main contributing factor(s) to John not being prepared?

- A. Personal appointments
- B. Inability to manage priorities
- C. Lack of planning
- C. B & C
- D. All of the above

The answer isC

Codes to Review for Possible Underlying Etiology or Alternate Diagnosis

- R00, Abnormalities of heartbeat
- R11, Nausea and vomiting
- R18, Ascites
- R19.7, Diarrhea
- R31, Hematuria
- R42, Dizziness
- R627, Failure to thrive
- R64, Cachexia
- R09.02, Hypoxia
- R55, Syncope
- R07.9, Chest pain
- R07.89, Other chest pain
- R10.9, Abdominal pain
- R10.13, Epigastric pain
- **R19.7, Diarrhea**
- **K529, Noninfective Gastroenteritis and colitis unspecified**

Possible Move From DRG 392 to 373

- From the risk factors, signs/symptoms, clinical indicators, and treatment listed below, please document your clinical opinion in the progress notes and discharge summary clarifying the diagnosis being treated and/or monitored.
- Enteritis—suspect bacterial requiring antibiotics
- Enteritis—suspect viral/noninfectious
- Other (please specify)
- Clinical indicators: H&P 1/29 acute gastroenteritis—viral versus bacterial, admit for management enteritis.
- Consult note General Surgeon: Suspect gastroenteritis-conservative treatment.
- PN IM 2/2: Acute gastroenteritis still having diarrhea, IV antibiotics Cipro, Levaquin, and Flagyl.
- Risk Factors: History of gastroenteritis, N/V/D.
- Treatment: IV NS bolus 1-liter, continuous IVF @ 75/hr, IV Cipro, IV Flagyl, IV Levaquin, GS consult, monitor labs



Clinical Documentation Specialist Role

Determine the condition responsible for inpatient admission.

Monitor the documentation for inconsistencies, ambiguity, and missing links to symptoms presented.

Query if needed to clarify.

Our job is important to providers for quality documentation, facilities for both quality and reimbursement, and families to assure the appropriate diagnoses are documented and supported.



Private Investigator

- Dig deeper to resolve underlying issues
- Think outside the box
- Look in places others would not think to look
- Continue to be diligent and persistent in your search for the truth, which in this case, is the search for the principal diagnosis



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Opportunities

- Opportunities include following these cases closer concurrently
 - Move to a different DRG
 - Addition of CC/MCC if patient acuity continues to increase
 - Improve overall specificity or documentation on any conditions that are a *history of* that may be addressed or treated during this admission



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Case Study #1



Potential
Financial
Impact=
\$23,733.92

52 y.o. male admitted with left-sided facial & arm numbness, dizziness suspect TIA. Symptoms are vague and not consistent with a stroke. TTE shows severe aortic stenosis and pericarditis. Hx of CABG and Stroke. The patient continues to experience dizziness, but numbness resolved shortly after admission. MRI indicates no acute infarction. Consult CV surgery for severe aortic stenosis. L heart catheterization was done preoperatively. AVR and redo sternotomy were done. Multiple progress notes after H and P indicate suspect TIA. Additional consulting Provider indicates not a TIA or CVA.

Query Opportunities: Etiology of dizziness

INITIAL DRG	POSSIBLE DRG	FINAL DRG
<ul style="list-style-type: none"> • DRG 982 • RW 2.9442 • GMLOS 4.6 • SOI/ROM 3/2 	<ul style="list-style-type: none"> • DRG 217 • RW 5.0623 • GMLOS 6.2 • SOI/ROM 3/2 	<ul style="list-style-type: none"> • DRG 217 • RW 5.0623 • GMLOS 6.2 • SOI/ROM 3/2
Provider responded symptoms were felt to not be a TIA or ischemic event and related to the patient's aortic stenosis		

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Case Study Workflow # 1



Query Opportunities: Etiology of Dizziness

ISSUE	OPPORTUNITY	RESULT
<ul style="list-style-type: none"> • No real stated cause of dizziness • Aortic stenosis needing AVR • Consulting physician states not a TIA 	<ul style="list-style-type: none"> • Clarify the cause of dizziness since not clear if TIA was known cause 	<ul style="list-style-type: none"> • Captured the known cause of the symptoms along with AVR repair
Provider responded symptoms were felt to not be a TIA or ischemic event and related to the patient's aortic stenosis		

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Case Study #2

65 y.o male was admitted with right upper extremity weakness, possible TIA, chest pain, cough, pleurisy, and bradycardia. VS on arrival HR 48, BP 108/68, O₂ Sat 98%, and RR 22. H & P Possible TIA. Will admit to telemetry and consult neuro and cardiology. CT and labs were done to include troponin. CT indicates an old infarction. CXR indicates possible fluid overload or pneumonia. Need to validate with a clinical exam. Neuro states possible TIA. EKG indicates an unspecified heart block. Cardio consult states chest pain is probably due to pleurisy and 2nd-degree block. Discussed probable need for pacer if bradycardia persists. PN Day 2: Probable TIA, weakness has resolved, and Bradycardia continues with HR of 40-42. MRI indicates no acute infarction. Treatment includes monitoring labs, IVF, neuro checks Q 2 hours, nebs q4, continuous telemetry monitoring, and a permanent pacer placed.

Potential
Financial
Impact=
\$7,674.91

Query Opportunities: TIA confirmation and cause of weakness

INITIAL DRG	POSSIBLE DRG	FINAL DRG
<ul style="list-style-type: none"> • DRG 069 • RW 0.7871 • GMLOS 2.1 • SOI/ROM 2/1 	<ul style="list-style-type: none"> • DRG 244 • RW 2.0633 • GMLOS 2.2 • SOI/ROM 1/1 	<ul style="list-style-type: none"> • DRG 244 • RW 2.0633 • GMLOS 2.2 • SOI/ROM 1/1

Responded weakness due to Bradycardia with noted 2nd degree AV block and TIA was ruled out.

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Case Study Workflow # 2

Query Opportunities: Cause of weakness and TIA confirmation

ISSUE	OPPORTUNITY	RESULT
<ul style="list-style-type: none"> • No clear stated cause of weakness • Status of TIA • 2nd-degree block noted along with permanent pacer 	<ul style="list-style-type: none"> • Clarify the cause of weakness and TIA status 	<ul style="list-style-type: none"> • Captured the cause of weakness and ruled out TIA

Responded weakness due to Bradycardia with noted 2nd degree AV block and TIA was ruled out.

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Case Study # 3

Potential
Financial
Impact
\$2,583.32

91 y.o. male was brought to the hospital after a syncopal spell at home. Admitted with hypoxemia and hypotension. VS 75/48, HR 85, O₂ sat 87%, RR 28. CXR done reveals infiltrates suggesting pneumonia. In addition, he has a history of CHF and takes Lasix. Day 2 progress note indicates syncope is possibly due to hypotension, acute on chronic CHF, and infiltrate. Echo indicates patient diastolic dysfunction. The patient continues to be SOB but has lessened with the use of high flow O₂, and Lasix. Treatment includes High Flow O₂ at 6-8 Liters, along with Lasix 40 IV bid and IV Rocephin.

Query Opportunities: Etiology of syncope, CHF acuity, acute respiratory failure, dx of pneumonia

INITIAL	OPPORTUNITY	FINAL
<ul style="list-style-type: none"> • DRG 312 • RW 0.8387 • GMLOS 2.3 • SOI/ROM 1/2 	<ul style="list-style-type: none"> • DRG 193 • RW 1.3120 • GMLOS 4.1 • SOI/ROM 4/4 	<ul style="list-style-type: none"> • DRG 291 • RW 1.2683 • GMLOS 4.1 • SOI/ROM 3/4

Provider responded stating syncope due to CHF and identified as acute diastolic CHF along with acute respiratory failure and PNA.

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Case Study Workflow # 3

Query Opportunities: Cause of syncope, CHF acuity, confirmation of pneumonia and acute respiratory failure

ISSUE	OPPORTUNITY	RESULT
<ul style="list-style-type: none"> • No clear cause of syncope • CHF acuity & confirmation of pneumonia • Possible Acute respiratory failure 	<ul style="list-style-type: none"> • Clarify the cause of syncope, CHF acuity, pneumonia validation, and acute respiratory failure 	<ul style="list-style-type: none"> • Captured the cause of syncope due to CHF, CHF acuity and confirmation of both pneumonia and acute respiratory failure

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CDI Challenges

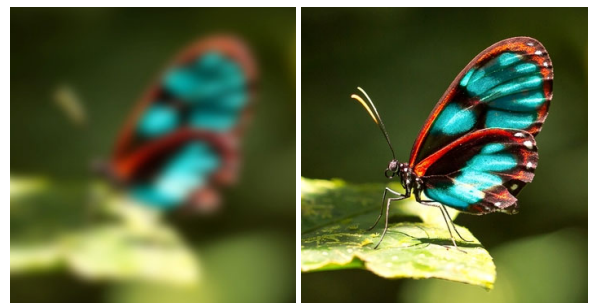


- Change is an inherent part of the process
 - New *Coding Clinics*
 - New coding guidelines
 - New codes
 - Removed codes
 - DRGs changes such as RW, GMLOS, and additional specificity needed CC/MCC's

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Gatekeepers

- We (CDI and coding) are the gatekeepers of the medical record and are responsible for making sure the picture is complete, consistent, accurate, and clear.
- This not only is helpful to the providers but to anyone who is auditing, reviewing, or analyzing information in the record.
- Provides a clearer picture for payers needing the medical record information



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References

- *ICD-10-CM and ICD-10-PCS Coding Handbook*. (2021). Chapter 12 Coding of Signs and Symptoms.
- *ICD-10-CM and ICD-10-PCS Coding Handbook*. (2021). Chapter 3 Coding of Signs and Symptoms.
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Thank you. Questions?

Vanessa.Elliott@wvumedicine.org

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