

THE PRINCIPLES OF INPATIENT CODING: DISSECTING THE INTRICATE LINK BETWEEN CLINICAL DOCUMENTATION AND CODING

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Reviewing inpatient prospective payment system (PPS) claims for the past 18 years, I have found that majority of the problems in inpatient coding can be traced to errors in principal diagnosis and complication/comorbidity (CC) diagnoses. In face-to-face meetings with hospitals and conferences with Health Information Management professionals, these two issues always come to light.

This article will provide you with valuable insight into the documentation requirements for accurate inpatient coding, help in decreasing time-consuming requests for clarifications and denial appeals, and see its ties into health care fiscal integrity and quality of patient care.

There are two elements that need to be present to arrive at the correct ICD-9-CM code: sharp coding skills as well as clear and concise clinical documentation. In clinical coding, we assign an established set of numbers to diagnoses and procedures. Coders can only apply a code to a diagnosis or procedure that is well documented.

Coding skills are divided into basic and advanced. Basic skills are learned in a didactic milieu, and advanced skills are acquired through experience. Basic skills involve knowing what, where, how, and when to code. Advanced coding skills are developed by experience, i.e., the countless hours spent perusing medical records, and understanding all the nuances and myriad of clinical scenarios – in effect, understanding the underpinnings of the official coding guidelines.

Good Documentation Required

In addition to all of the above skills, clear and concise medical record documentation is needed to apply one's coding skills. Good documentation reduces gray areas in coding. It pre-empts misinterpretation and creative (a.k.a. assumptive) coding.

Medical record documentation encompasses notations from physicians, nurses, and other health care practitioners, as well as results of therapeutic and ancillary diagnostic procedures. For acute inpatient hospital stays, ICD-9-CM codes are only applied to diagnoses and procedures that are shown to have clinical significance as documented by the physician. It is imperative that physician

documentation in the progress notes address the conditions a patient is ill with as well as the significance of results of laboratory and other diagnostic tests performed.

Diagnosis coding is a more difficult area than procedure coding because of the complexity of arriving at a diagnosis and the sequencing of diagnoses and this article will focus on these areas. The principles governing the correct code assignment and sequencing of diagnoses are based on the American Hospital Association's Coding Clinic guidelines, developed by the Cooperating Parties for ICD-9-CM. The National Center for Health Statistics (NCHS) and the Centers for Medicare and Medicaid Services (CMS) receive assistance from the American Health Information Management Association (AHIMA), the American Medical Association (AMA), and the American Hospital Association (AHA) in determining official advice for interpretation of the basic principles intended by the classification systems.

Diagnosis Documentation Specificity

The documented diagnosis has to be specific. Case in point – pneumonia caused by specific bacteria should be documented as to the specific organism (e.g., pneumonia due to *Klebsiella pneumoniae*). If the physician documents only "Pneumonia," even with positive sputum culture for *Klebsiella pneumoniae* and orders therapy with antibiotics to which the organism is sensitive, this will be coded to 486 – Pneumonia, organism unspecified, rather than 482.0 – Pneumonia due to *Klebsiella pneumoniae*. This constitutes a big difference in DRG payment – from a simple pneumonia DRG to a complex pneumonia DRG and is a frequent topper in the OIGs target list for possible fraud and abuse.

Coders Cannot Diagnose

It is important to note that coders cannot assume a diagnosis from clinical information in the medical record for acute inpatient hospital stays.¹ (Although the outpatient coding guidelines concur, there are some slight differences in the ICD-9-CM coding for diagnostic tests specific for outpatient services inherently because of the short patient encounter episode.²) "Clinical information" refers to laboratory and other ancillary results. The physician is required to clearly document the diagnosis in the medical record before the coder can assign the appropriate ICD-9-

¹ Office of Inspector General, Department of Health and Human Services Compliance Program Guidance for Hospitals. Washington, DC: Office of Inspector General, 1998

² Medicare Hospital Manual Transmittal, September 12, 2002

CM code. There are many factors and nuances that go into diagnosing patients that physicians have been educated and trained to recognize. Coders are not trained as physicians to distinguish false positive or negative diagnostic tests (e.g., culture & sensitivity tests, x-rays, pathology reports). Sputum cultures grow organisms not causing any infection in the lungs (contaminants or colonizers). Blood cultures can be negative due to factors such as: fastidious organisms, prior antibiotic therapy, growth inhibitory factors, and human or mechanical errors. Only 60% of patients with clinical evidence of sepsis have positive blood cultures.

Chest x-rays of patients with pneumonia may be negative because of low white blood cell count (WBC) or diminished fluid volume. Pneumonic infiltrates result from the body's defense mechanisms against foreign invaders. Killer white blood cells and other immune system elements in the plasma extravasate into the lung's alveoli to fight the offending bacteria thus forming alveolar or interstitial infiltrates demonstrated on chest x-ray. Patients who either have low WBC or decreased fluid volume will not be able to mount a counter-attack. Hence, a false negative chest x-ray. It would be inappropriate to have coders pick up these subtle distinctions and assume that a diagnosis is present or not. Chest x-rays may also show innocuous shadows that look like and are reported as COPD in patients that have no COPD.

Pathology reports come back with pathological diagnoses that may or may not be clinically significant. Uterine curettage may report hyperplastic changes that are concomitant with normal endometrial cycle changes. A breast specimen from a radical mastectomy may be negative for carcinoma after an initial local excision biopsy captures all the cancer tissue, but it does not mean that the patient does not have a diagnosis of breast CA.

Another example of the importance of precise documentation is in the diagnosis of "Anemia." Unless the physician documents that the anemia is due to acute blood loss or is posthemorrhagic (or words to that effect), this will be coded to 285.9 – Anemia, unspecified. It does not matter if there is a documented source of bleeding (e.g., GI bleeding), low hemoglobin/hematocrit (Hb/Hct) and that the patient was transfused. Acute drops in Hb/Hct can also be due to dilutional anemia, wherein the patient's Hb/Hct falls caused by a medically indicated aggressive intravenous hydration therapy. The use of blood transfusions is not limited to blood loss. Patients in renal failure with low Hb/Hct can have indications for blood transfusions.

Documentation is Part of Care

It is only the physician attending to the patient who will be able to recognize the intricacies that each individual case brings. He or she bears responsibility to document these fine points in the patient's medical record – not just for purposes of coding, but for continuity of patient care. Physician documentation should provide an accurate depiction of the patient encounter because it inherently affects quality of patient care. It has been said before – the medical record should be able to stand alone and provide a clear picture of the patient encounter. Contrary to the old adage, "*the less said - the better,*" insufficient documentation only brings more inquiries and potential liability.

Principal Diagnosis (PDX)

This refers to the condition established after study to be chiefly responsible for occasioning the patient's admission to the hospital for care.³ The selection of principal diagnosis is determined by the circumstances of admission, diagnostic workup and/or therapy provided.⁴ The condition that best satisfies the three criteria is the principal diagnosis.

The documented circumstances of admission, diagnostic workup and/or treatment should support and reflect the principal diagnosis. Among the three criteria, the circumstances of inpatient admission always govern the selection of the principal diagnosis. Circumstances of admission refer to the chief complaint, as well as signs and symptoms of the patient on admission. The reason for the patient's admission has to be clearly identified. The principal diagnosis is the definitive diagnosis that was established and should relate to the chief complaint on admission. If it is unclear, the physician should be queried and then corroborated with supporting documentation in the medical record.

Co-equal Principal Diagnoses

When two or more diagnoses equally meet the criteria for principal diagnosis as determined by the circumstances of admission, diagnostic work-up, and/or therapy provided (and the Alphabetic Index, Tabular List, or another coding guideline does not provide sequencing direction), any one of

³ Uniform Hospital Discharge Data Set

⁴ American Hospital Association's Coding Clinic for ICD-9-CM, 1990:2Q:p.4 PDX#4,5

the diagnoses may be sequenced first.⁵ For example, a patient presents with multiple problems: shortness of breath, fever, and chest pain. Chest x-ray demonstrates an exacerbated CHF, examination reveals acute bronchitis, and prior history and current EKG findings are consistent with unstable angina. The three conditions were treated with medications. All three diagnoses equally meet the criteria for the definition of principal diagnosis and the hospital can sequence any one as the principal diagnosis. But let's say this patient undergoes coronary arteriography revealing coronary artery disease (CAD) with 85-90% blockage of two prominent branches and has a percutaneous transluminal coronary angioplasty (PTCA). In this scenario, the workup and therapy criteria clearly distinguish CAD, identified as the etiology of the patient's unstable angina, to be the principal diagnosis.

Circumstances of Admission

Let's put another twist to a different scenario. A patient presents with fever, hypotension, and altered mental status. Impression on admission is sepsis. A few hours after admission, the patient develops chest pain. Work up shows the following significant findings: Blood C&S – Staphylococcus aureus; Cardiac enzymes – elevated CPK MB. Patient was treated with IV antibiotic to which the organism was susceptible and undergoes cardiac catheterization and coronary artery bypass graft (CABG). Impression documented in Progress notes shows Acute MI and Sepsis due to Staphylococcus aureus. The Final Diagnoses in Discharge summary lists in order, Acute MI and Sepsis due to Staphylococcus aureus. One may conclude that since the CABG far outweighs IV antibiotics, the AMI should be the PDX. However, the AMI developed after a few hours into the admission and does not satisfy the criteria of circumstances of admission. The circumstances of admission always govern the selection of principal diagnosis. Hence, Staphylococcus aureus sepsis is the appropriate principal diagnosis.

Other Diagnoses (ODX)

Also known as "secondary diagnoses," or "additional diagnoses," these are conditions that either coexist at the time of admission or develop subsequently and affect patient care for the current hospital episode. "Coexisting at the time of admission" means that the condition was present on or before admission but was not the main focus of the admission. For example, a patient with long

⁵ AHA Coding Clinic, 90:2Q:p.4 PDX#5

standing CHF and/or COPD comes in with clinical evidence of sepsis. Although the CHF and/or COPD may have affected patient care, sepsis occasioned the admission. "Affecting patient care" means the condition required either: clinical evaluation, therapeutic treatment, diagnostic procedures, extended the length of hospital stay, or increased nursing care and/or monitoring.⁶ Thus, when an additional condition incurs consumption of hospital resources it is considered a valid secondary diagnosis.

The Centers for Medicare and Medicaid Services (CMS), formerly known as HCFA, has developed a standard list of diagnoses that are recognized as complications and comorbidities (CC) for the DRGs. When a CC is present as a secondary diagnosis, it could affect DRG assignment. Those conditions that coexisted at the time of admission are called "co-morbid conditions," while those that develop subsequently in the current hospital episode are termed, "complications." Thus, we have DRGs with and without CCs. CCs are a type of other diagnoses (ODX) that statistically show a substantial increase in utilization of hospital resources. It has to be combined with a corresponding PDX to affect the DRG. Note that complications, in DRG terminology, do not only refer to errors in medical or surgical workup or treatment.

DRGs affected by the appearance of a CC show a substantial increase in utilization of hospital resources in the majority of cases. Only one CC is needed to change a DRG without CC to a DRG with CC. However, not all DRGs are with or without CCs. There are a number of stand-alone DRGs that are not affected by the presence or absence of CCs (e.g., DRG 014 – Specific Cerebrovascular Disorders Except Transient Ischemic Attack and DRG 015 – Transient Ischemic Attack and Precerebral Occlusions). With the stand-alone DRGs, the DRG will only change if the principal diagnosis is changed or a significant surgical procedure is introduced.

Compliance

Compliance mandates that all codes and supporting documentation should be in the medical record prior to billing. Hospital processes should be in place to ensure it. Appropriate use of the physician query process facilitates clarification of gray areas and ensures that supporting documentation is in place. Physician champions, concurrent coders/documentation specialists, and case managers' involvement in concurrent documentation review aids in the timely resolution of emerging problems.

⁶ AHA Coding Clinic, 90:2Q:pp. 12-16

The OIG Compliance Guidance⁷ states, "With respect to reimbursement claims, a hospital's written policies and procedures should reflect and reinforce current federal and state statutes and regulations regarding the submission of claims and Medicare cost reports. The policies must create a mechanism for the billing or reimbursement staff to communicate effectively with the clinical staff. Policies and procedures should:

- *Provide for proper and timely documentation* of all physician and professional services *prior to billing* to ensure that only accurate and properly documented services are billed;
- Emphasize that *claims should be submitted only when appropriate documentation supports the claims* and only when such documentation is maintained and available for audit and review..."

The Quality Improvement Organization (QIO) medical record review process is intended to validate that the medical record information substantiates the diagnosis and procedure codes submitted by the hospital on its claim for Medicare payment. Medical records requested for retrospective medical record review are selected from Medicare's paid claims file – therefore, all of the coding and documentation should already be in place.

Ultimately, what physicians document in the medical record are translated into codes, collected in a national database (MedPAR), analyzed and utilized in reimbursement, regulatory compliance, financial planning, quality management, physician profiling, and managed care contracting. Documentation is the key to accurate clinical coding, validating length of stay, utilization of resources, physician profiling, case management, severity of illness, risk of mortality, quality management, risk management, clinical outcomes, critical pathways, regulatory compliance, JCAHO, managed care, and reimbursement. Bottom line – it is critical to both the financial integrity of a health care institution and the quality of patient care. An old Latin proverb put it best, "Vox audita perit; Litera scripta manet." It means the spoken word perishes, but the written word remains.

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⁷ Office of Inspector General, Department of Health and Human Services Compliance Program Guidance for Hospitals. Washington, DC: Office of Inspector General, 1998