In our over 60 years’ worth of cumulative experience in healthcare practice and management, we have become intimately familiar with the difficulties hospitals face in achieving optimal financial health. And there is one challenge that has reared its head more frequently than any other at the hundreds of hospitals we’ve worked with: how to accurately capture the severity and complexity of illnesses in hospitalized patients.

All too often, physicians are unaware of the precise terminology required to allow proper coding, and coders’ lack of clinical training keeps them from recognizing diagnoses that should be clarified before billing. Successfully bridging this cultural divide by equipping physicians, documentation specialists, and coders with the knowledge they need has become our specialty. One of our chief goals is to help hospitals achieve complete and accurate documentation in the medical record in a way that can be translated into precise ICD-10 coding and more accurate DRG assignment.

Why is this so important? The obvious answer is that hospitals deserve to be reimbursed for the care they provide. But the importance of clinical documentation extends well beyond the immediate impact of reimbursement. Accurate DRG assignment is crucial for evaluating quality indicators, resource consumption, and outcome measures.

For example, consider the physician who fails to document sepsis in patients with UTI, or whose cases of serious life-threatening pneumonia are coded as simple pneumonia. His or her complication rates, mortality figures, length of stay, and other indicators of quality of patient care will suffer. Or consider the surgery practice whose records regularly omit major comorbidities. Their outcome measures for seriously ill patients will be unwittingly compared with those of patients with no comorbid conditions — and the hospital’s performance measures will be unaccountably poor. Indeed, the only way for hospitals to truly understand where improvements need to be made is to be able to rely on accurate records. Clinical documentation is ultimately a matter of patient care.
INTRODUCTION

We created this reference guide to provide documentation specialists and coding professionals with the clinical information and guidance they need to help physicians accomplish thorough documentation. This guide grew out of our desire to create a simple, easy-to-use guide that would stay with our clients long after we’d completed our consultancy at their hospital and for anyone seeking to increase his or her mastery of the profession.

We trust you will find this as a useful tool in addressing the daily complexities of clinical documentation. The ultimate goal is not just more accurate coding and better reimbursement, but improved quality and outcomes for both physician and hospital.

Each section of this guide has a different purpose:

The **Guidelines** section provides the most important guidelines and coding rules for DRG assignment and other important topics. Refer to these guidelines frequently.

The **Key References** section provides detailed clinical definitions, diagnostic criteria, treatment, coding and documentation challenges, and references for the most important conditions.

The **Comorbid Conditions** section includes conditions with a high impact focus for MS-DRG, HCCs and Pay for Performance, and APR-DRG, and clinical indicators to help you identify them in the record.

The **DRG Tips** section includes tips for alternative DRG selection and includes select DRGs which, in our experience, have a high likelihood of another principal diagnosis, MCC or CC, or procedure.

The **MS-DRG Table** is a complete list of the MS-DRGs for FY2017, their relative weights, and GMLOS for quick reference.
CODING RULES—OVERVIEW

The authoritative sources for coding and reporting are listed below and should be reviewed and referenced routinely for specific situations and circumstances to ensure accurate coding.

- ICD-10-CM and ICD-10-PCS Coding Classifications
- ICD-10-CM Official Coding Guidelines for Coding & Reporting
- ICD-10-PCS Official Coding Guidelines for Coding & Reporting
- AHA Coding Clinic for ICD-10-CM and ICD-10-PCS

Note that the instructions and coding conventions in ICD-10 take precedence over the Official Coding Guidelines, which in turn take precedence over Coding Clinic advice. Coding Clinic guidance for ICD-10 began 4th Quarter 2012. Prior Coding Clinic advice will stand as long as there is nothing new published in ICD-10-CM and ICD-10-PCS to replace it (see Coding Clinic, Fourth Quarter 2015, p. 20).

ICD-10-CM tabular and index structure is basically the same as ICD-9. The ICD-10-CM coding guidelines are very similar to ICD-9-CM with some significant changes in content but otherwise unchanged.

**ICD-10-CM defines two types of Excludes notes:**

- Excludes1 note means “Not Coded Here.” The code excluded should not be used at the same time as the code above the Excludes1 note. The two conditions cannot be coded together, except when the two conditions are clearly unrelated to each other.
- Excludes2 note means “Not Included Here.” The condition excluded is not part of the condition it is excluded from but a patient may have both conditions at the same time. It is acceptable to code both together.

**EXAMPLE**

Malnutrition (E40-E46)

**Excludes1:**
- Intestinal malabsorption (K90.-)
- Sequelae of protein-calorie malnutrition (E64.0)

**Excludes2:**
- Nutritional anemias (D50-D53)
- Starvation (T73.0)
DEFINITION OF THE PRINCIPAL DIAGNOSIS

Official Coding Guidelines (OCG) Section II specifies rules for the selection of the principal diagnosis, first noting that the definition is:

“That condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.”

Consider WHY the patient was admitted to the hospital and could not go home. Many patients are admitted with several medical problems, but those that could have been individually treated as an outpatient or observation are unlikely to be chiefly responsible for the admission.

The condition (or at least some signs or symptoms referable to the condition) must be present on admission. In some cases it may be several days before the provider arrives at a definitive diagnosis. This does not mean that the condition was not present on admission if the signs and symptoms of it were present on admission.

OCG Appendix I—Present on Admission (POA) Reporting Guidelines includes an important definition of POA with implications for assigning the principal diagnosis:

“Diagnoses subsequently confirmed after admission are considered present on admission if at the time of admission they .... constitute an underlying cause of a symptom that is present at the time of admission.”

The selection of the principal diagnosis is based on the entire medical record: “The entire record should be reviewed to determine the specific reason for the encounter and the conditions treated.” (OCG page 1).
1. TWO OR MORE DIAGNOSES THAT EQUALLY MEET THE CRITERIA FOR PRINCIPAL DIAGNOSIS

“In the unusual instance when two or more diagnoses equally meet the criteria for principal diagnosis as determined by the circumstances of admission, diagnostic workup, and/or therapy provided and the Alphabetic Index, Tabular List, or another coding guideline does not provide sequencing direction, any one of the diagnoses may be sequenced first.” (OCG Section II.C).

This guideline is the basis for the term “co-equal” diagnoses, but more importantly for the concept of “focus” of admission: the maxim that requires coders to evaluate the entire record to see which of several potential principal diagnoses may have been the predominant “focus” of the admission based on the circumstances, workup, and therapy provided.

Circumstances of admission is a broad term, but important considerations are:

- Severity of each condition
- Greatest risk to life or other complications
- Complexity of care, evaluation, and management
- Number and types of consultants or procedures and their risks
- Medications required, risks, complications, route of administration
- Level of care required for each condition individually (observation, inpatient, telemetry, intensive care)
- Intensity of monitoring (nature and frequency of vital signs, nursing time, etc.)
- Plans for follow-up evaluation, management, and care

When one condition is obviously predominant, the coder must select it as principal diagnosis unless coding guidance states otherwise.

**EXAMPLE**

Patient admitted with CHF and pneumonia. Patient given IV Lasix and IV antibiotics. Either may be sequenced as the principal diagnosis.
2. TWO OR MORE INTER-RELATED CONDITIONS, EACH POTENTIALLY MEETING THE DEFINITION OF PRINCIPAL DIAGNOSIS

“When there are two or more interrelated conditions (such as diseases in the same ICD-10-CM chapter or manifestations characteristically associated with a certain disease) potentially meeting the definition of principal diagnosis, either condition may be sequenced first, unless the circumstances of the admission, the therapy provided, the Tabular List, or the Alphabetic Index indicate otherwise.” (OCG II.B).

**EXAMPLE** Patient is admitted to the ICU with respiratory failure due to severe exacerbation of COPD. A pulmonary consultant is involved. Treatment includes IV antibiotics, steroids, oxygen, pulse oximetry, and aggressive respiratory therapy modalities. Either may be sequenced as principal diagnosis.

3. UNCERTAIN DIAGNOSIS

“If the diagnosis documented at the time of discharge is qualified as “probable,” “suspected,” “likely,” “questionable,” “possible,” “still to be ruled out,” or other similar terms indicating uncertainty, code the condition as if it existed or was established.

The bases for these guidelines are the diagnostic workup, arrangements for further workup or observation, and initial therapeutic approach that correspond most closely with the established diagnosis.” (OCG Section II.H).

This guideline is applicable only to inpatient admissions, not outpatient visits.

*Exception:* Code only confirmed cases of HIV, Zika, and influenza due to certain viruses in categories J09-J10—such as H1N1, avian, novel influenza A.

Other terms that indicate uncertainty are “consistent with,” “compatible with,” “indicative of,” “suggestive of,” “comparable with,” “appears to be” (per Coding Clinic, Third Quarter 2005). “Rule out” conditions are ambiguous and should be clarified whether ruled-in or ruled-out.
**EXAMPLE**
“RLL pneumonia possibly due to aspiration.” Assign code J69.0 for aspiration pneumonia.

*Note:* Many coding experts interpret “at the time of discharge” to imply documentation in the discharge summary or final progress note. However, the second sentence of this rule suggests that the diagnostic workup, arrangements for further workup or observation, and initial therapeutic approach documented throughout the entire record should be considered when interpreting and applying this rule. The OCG also state, “The entire record should be reviewed to determine the specific reason for the encounter and the conditions treated.”

The key issue is to ensure the uncertain condition is not ruled out based on the entire medical record and is not stated otherwise at the time of discharge. For example, “possible gram-negative pneumonia” would not be assigned if antibiotics for these organisms were discontinued or it was later determined to be pneumococcal pneumonia.

**4. CODES FOR SYMPTOMS, SIGNS, AND ILL-DEFINED CONDITIONS**

“Codes for symptoms, signs, and ill-defined conditions from Chapter 18 are not to be used as principal diagnosis when a related definitive diagnosis has been established.” (OCG Section II.A).

**EXAMPLE**
Syncope due to cardiac arrhythmia. Cardiac arrhythmia is the principal diagnosis, syncope is a secondary diagnosis.

Do not assign a separate code at all for signs and symptoms that are routinely associated with a disease process or when a related definitive diagnosis has been established (confirmed) as the cause. See OCG Sections I.B.4 and I.C.18.a and b.

**EXAMPLE**
Viral gastroenteritis with fever, abdominal pain, nausea, vomiting, diarrhea. Code only viral gastroenteritis.

When applying this rule, remember that Rule #3 treats uncertain diagnoses as “established.”
CODING RULES—PRINCIPAL DIAGNOSIS

EXAMPLE  Fever possibly due to UTI. Code UTI only.

See Signs, Symptoms and Unspecified Codes section for further details.

5. ORIGINAL TREATMENT PLAN NOT CARRIED OUT

“Sequence as the principal diagnosis the condition, which after study occasioned the admission to the hospital, even though treatment may not have been carried out due to unforeseen circumstances.” (OCG Section II.F).

EXAMPLE  A patient with cholecystitis was admitted to the hospital for a cholecystectomy. Prior to surgery, the patient fell and sustained a left femur fracture. The surgery was canceled and a hip pinning was carried out on the second hospital day.

The principal diagnosis remains cholecystitis, since it necessitated the admission to the hospital. The fractured femur is sequenced as a secondary diagnosis since it occurred during the hospital stay.

6. COMPLICATIONS OF SURGERY AND OTHER MEDICAL CARE

“When the admission is for treatment of a complication resulting from surgery or other medical care, the complication code is sequenced as the principal diagnosis. If the complication is classified to the T80-T88 series and the code lacks the necessary specificity in describing the complication, an additional code for the specific complication should be assigned.” (OCG Section II.G).

See Complications of Care section for further details.

EXAMPLES  (1) A patient was discharged two days following a hysterectomy. On the second day at home, she strained lifting a small child. She was readmitted with wound dehiscence. Sequence the wound dehiscence as the principal diagnosis.
(2) A patient is admitted with respiratory failure and large iatrogenic pneumothorax three days following outpatient thoracentesis for malignant pleural effusion. Iatrogenic pneumothorax is the principal diagnosis.
7. ADMISSION FROM OBSERVATION UNITS

Admission from medical observation: “When a patient is admitted to an observation unit for a medical condition, which either worsens or does not improve, and is subsequently admitted as an inpatient of the same hospital for this same medical condition, the principal diagnosis would be the medical condition which led to the hospital admission.” (OCG Section II.I.1).

Sometimes the reason for transition from observation is not entirely clear in the record and may require thoughtful interpretation of the clinical circumstances or even a query for clarification.

On occasion, a patient is treated as observation for several days before it’s recognized that no inpatient order was given. The principal diagnosis must be something that still required evaluation and was the focus of inpatient care at the time the inpatient order was written.

**EXAMPLE**  
A patient is treated in an observation unit for 16 hours with an exacerbation of COPD, then admitted as an inpatient for treatment of a pulmonary embolism discovered on chest CT. Pulmonary embolism is principal diagnosis.

Admission from postoperative observation: “When a patient is admitted to an observation unit to monitor a condition (or complication) that develops following outpatient surgery, and then is subsequently admitted as an inpatient of the same hospital, hospitals should apply the Uniform Hospital Discharge Data Set (UHDDS) definition of principal diagnosis as “that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.” (OCG Section II.I.2).

8. ADMISSION FROM OUTPATIENT SURGERY

“When a patient receives surgery in the hospital’s outpatient surgery department and is subsequently admitted [directly] for continuing inpatient care at the same hospital, the following guidelines should be followed in selecting the principal diagnosis for the inpatient admission:
CODING RULES—PRINCIPAL DIAGNOSIS

- If the reason for the inpatient admission is a complication, assign the complication as the principal diagnosis.
- If no complication, or other condition, is documented as the reason for the inpatient admission, assign the reason for the outpatient surgery as the principal diagnosis.
- If the reason for the inpatient admission is another condition unrelated to the surgery, assign the unrelated condition as the principal diagnosis.” (OCG II.J). See also OCG II.I.2.

EXAMPLES  
(1) Patient admitted for postoperative bleeding following outpatient TURP; postoperative bleeding is the principal diagnosis.
(2) Patient being observed for 24 hours following lumbar kyphoplasty develops rapid atrial fibrillation requiring admission; atrial fibrillation would be the principal diagnosis.
(3) Elderly patient with chronic cholecystitis admitted for 3 days following uncomplicated elective laparoscopic cholecystectomy without further explanation before being transferred to a SNF; chronic cholecystitis is the principal diagnosis.

9. TWO OR MORE COMPARATIVE/CONTRASTING DIAGNOSES

“In those rare instances when two or more contrasting or comparative diagnoses are documented as “either/or” (or similar terminology), they are sequenced according to the circumstances of the admission. If no further determination can be made as to which diagnosis should be principal, either diagnosis may be sequenced first.” (OCG Section II.D).

EXAMPLE  “Acute pancreatitis vs. acute cholecystitis”: Either may be sequenced as principal diagnosis.
**CODING RULES—SECONDARY DIAGNOSIS**

*Other diagnoses are defined as:* “All conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded.” (OCG Section III).

The definition for other diagnoses is additional conditions (either present on admission or occurring during admission) that affect patient care in terms of requiring:

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

Secondary conditions which are documented but which do not meet one of these five requirements should not be coded.

Chronic conditions such as hypertension, congestive heart failure, asthma, COPD, Parkinson’s disease, diabetes mellitus, and many others typically require chronic treatment and meet the above definition.

Morbid obesity would be considered clinically significant since this condition may require “increased nursing care” at a minimum, not to mention complexity of care and high risk of medical/surgical complications. However, documentation of “CHF” on an anesthesia assessment, without any further indications of ongoing treatment, does not suggest clinical significance and thus the condition would not be coded.

OCG Section III states that the Uncertain Diagnosis rule also applies to the assignment of secondary diagnoses.

**Abnormal findings:** Laboratory, x-ray, pathology, and other diagnostic results are not coded and reported unless the provider indicates their clinical significance. If the findings are outside the normal range and the attending provider has ordered other tests to evaluate the
condition or prescribed treatment, it is appropriate to ask the provider whether the abnormal finding should be added. (OCG Section III.B).

**Examples:** Patient with serum sodium of 125. Do not code unless physician states “hyponatremia.”

Small cell carcinoma on pathology report must be documented by a provider in the body of the medical record.

**Greater specificity:** Although perhaps not widely understood, it has been an acceptable inpatient coding practice to assign greater specificity of established diagnoses based on certain documentation or test results.

According to Coding Clinic, First Quarter 2013, p. 28, “If the x-ray report provides additional information regarding the site for a condition that the provider has already diagnosed, it would be appropriate to assign a code to identify the specificity that is documented in the x-ray report.”

The same can be said for other situations where ICD-10 provides greater specificity for an established diagnosis such as:

- Laterality and involved artery for a diagnosed nonspecific CVA from CT or MRI/MRA
- Location or involved artery for an unspecified diagnosis of STEMI obtained from the EKG

The opportunity and need for this coding practice is magnified because of the greater specificity offered by ICD-10. This allows the coder to capture greater diagnostic detail in code assignment for data integrity without placing an unreasonable, unnecessary burden on providers.

A good “rule of thumb” is to never assign greater specificity from a test result or other documents without provider documentation if it will impact the DRG resulting in higher payment.
CODING RULES—SECONDARY DIAGNOSIS

**Conditions From Previous Encounters:** “Documentation from the current encounter should clearly reflect those diagnoses that are current and relevant for that encounter...When reporting recurring conditions and the recurring condition is still valid for the outpatient encounter or inpatient admission, the recurring condition should be documented in the medical record with each encounter/admission... It is inappropriate to go back to previous encounters to retrieve a diagnosis without physician confirmation.” (Coding Clinic, Third Quarter 2013, p. 27).

Therefore, it would be appropriate to query the physician regarding a condition from a previous encounter based on indicators from the current encounter and pertinent information from the previous encounters if the condition meets the definition of a secondary diagnosis (being treated, clinically evaluated, etc.).

The OCG has never prohibited this practice when a prior diagnosis from previous encounters was pertinent to the current encounter.

**According to OCG Section III Reporting Additional Diagnoses:** “Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded. Some providers include.... resolved conditions or diagnoses.... from a previous admission **that have no bearing** on the current stay. Such conditions are not to be reported and are coded only if required by hospital policy.”

Therefore, a diagnosis from a previous encounter that **does have a bearing** on the current stay should be documented, as Coding Clinic says, so it can be currently coded. A query for clarification is the proper method for obtaining this information.
The Medicare MS-DRG system is used primarily for patients over age 65. To better accommodate the entire patient population, both adult and pediatric, 3M and the National Association of Children’s Hospitals and Related Institutions collaboratively developed the 3M APR-DRG system in 1990.

APR-DRG is a proprietary, severity-adjusted system often used for quality assessment programs, such as the Agency for Health Research and Quality (AHRQ), and many state database performance reporting systems. Over half the states have adopted APR-DRGs for inpatient payment for either Medicaid or Blue Cross.

APR-DRGs are similar in structure to MS-DRGs, with generally comparable base DRGs split into severity subclasses based on secondary diagnoses. Each APR base DRG has four subclasses of severity of illness (SOI) and four subclasses of risk of mortality (ROM), as opposed to as many as three severity levels for MS-DRGs using MCCs and CCs. See Table 1 below. Consequently, there are more APR-DRGs than MS-DRGs (1,256 vs. 757).

Table 1: **MS-DRG VS. APR-DRG**

<table>
<thead>
<tr>
<th>MS-DRG</th>
<th>APR-DRG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main Driver:</td>
<td>Main Driver:</td>
</tr>
<tr>
<td>Principal Diagnosis or</td>
<td>Principal Diagnosis or</td>
</tr>
<tr>
<td>Surgical Procedure</td>
<td>Surgical Procedure</td>
</tr>
<tr>
<td>Secondary Diagnosis:</td>
<td>Secondary Diagnosis:</td>
</tr>
<tr>
<td>MCC</td>
<td>SOI 4 (Extreme)</td>
</tr>
<tr>
<td>CC</td>
<td>SOI 3 (Major)</td>
</tr>
<tr>
<td>Non-CC</td>
<td>SOI 2 (Moderate)</td>
</tr>
<tr>
<td></td>
<td>SOI 1 (Minor)</td>
</tr>
</tbody>
</table>

**APR-DRG assignment**: Assignment of APR-DRGs is highly complex; statistical algorithms and rerouting logic are used to determine the final DRG and severity subclass. By comparison, MS-DRGs are straightforward, intuitive, and transparent.
The APR-DRG system assigns discharges to a DRG SOI subclass as follows:

1. Assign base DRG by principal diagnosis and principal procedure.
2. Determine the severity of illness (SOI) level for each secondary diagnosis.
3. Assign the final DRG/SOI subclass based on the combination and hierarchy of all diagnoses.

### Table 2: Example of APR-DRG 45

<table>
<thead>
<tr>
<th>Base DRG</th>
<th>SOI</th>
<th>DRG Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>45</td>
<td>1</td>
<td>CVA &amp; Precerebral Occlusion w Infarct</td>
</tr>
<tr>
<td>45</td>
<td>2</td>
<td>CVA &amp; Precerebral Occlusion w Infarct</td>
</tr>
<tr>
<td>45</td>
<td>3</td>
<td>CVA &amp; Precerebral Occlusion w Infarct</td>
</tr>
<tr>
<td>45</td>
<td>4</td>
<td>CVA &amp; Precerebral Occlusion w Infarct</td>
</tr>
</tbody>
</table>

The more common MS-DRG MCCs are classified in APR-DRG as SOI Level 3 or 4, CCs are typically SOI 2 or 3, and most non-CCs are SOI 1. Some non-CCs are assigned as SOI 2.

While a single MCC or CC determines the MS-DRG, multiple secondary diagnoses can influence the APR-DRG. However, not all secondary diagnoses make a difference in the final APR-DRG assignment. In most circumstances, only two or three secondary diagnoses with the highest SOI levels are needed to determine the final APR-DRG SOI subclass.

The default SOI level is included in the *Comorbid Conditions* listing of this guide. See also in this section a separate listing of non-CC diagnoses with SOI 2 or 3 for adults and pediatrics.

**Optimal APR-DRG Severity of Illness:** Not all CDI and coding specialists have access to the APR-DRG grouper to identify the SOI/ROM subclass. As an alternative, CDI needs a strategy to optimize severity classification working only with MCCs and CCs in the MS-DRG system.
Using the SOI subclass of the most common and important MCC/CCs from the Comorbid Conditions section of this guide, CDI can determine the likely APR-DRG SOI/ROM in most cases:

**Table 3: APR-DRG SOI Levels**

<table>
<thead>
<tr>
<th>Combination of Secondary Diagnosis SOI Levels</th>
<th>APR-DRG SOI Subclass*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two SOI 4, or One SOI 4 and two SOI 3</td>
<td>4 (Extreme)</td>
</tr>
<tr>
<td>Two SOI 3, or One SOI 3 and two SOI 2</td>
<td>3 (Major)</td>
</tr>
<tr>
<td>One or more SOI 2</td>
<td>2 (Moderate)</td>
</tr>
</tbody>
</table>

*APR rerouting logic, exclusions, and patient age may result in a different SOI subclass.

Alternatively (see Table 4 below), obtaining a combination of two or three MCC/CCs will usually result in a reasonable SOI classification.

**Table 4: Severity Impact Using MCC/CCs**

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two MCCs</td>
<td>If only one MCC is identified and clinical indicators of another MCC are present, query the physician for this second MCC.</td>
</tr>
<tr>
<td>One MCC + Two CCs</td>
<td>If only one MCC is identified and there are no clinical indicators for a second MCC, search and query for up to two additional CCs.</td>
</tr>
<tr>
<td>Two CCs</td>
<td>If there are no clinical indicators for any MCC, search and query for up to two CCs.</td>
</tr>
</tbody>
</table>

With experience, CDI can learn to combine both strategies. While imperfect, the result will usually be a solid SOI classification without an APR-DRG grouper. In addition, documentation and coding of two MCC or CCs guards against RAC DRG changes, since RACs often focus on cases with only one MCC or CC.
ICD-10, as in ICD-9, has a provision called the etiology/manifestation (E/M) convention for a few specific diagnoses that requires the underlying condition (cause/etiology) to be sequenced first followed by its manifestation (effect).

It applies only to a limited number of conditions and their manifestations that are specifically identified by Index entries and Tabular List instructional notes. The rule does not apply to codes for other conditions without these specific instructions.

Using an encoder/grouper simplifies the process since the required condition-specific sequencing is incorporated in the encoder logic. ICD-10-CM has substantially reduced the number of conditions subject to the E/M convention because so many of these are now assigned as a single combination code rather than two codes, such as diabetes mellitus.

**OCG Section I.A.13 describes the E/M convention:** “Certain conditions have both an underlying etiology and multiple body system manifestations due to the underlying etiology. For such conditions, ICD-10-CM has a coding convention that requires the underlying condition be sequenced first followed by the manifestation. Wherever such a combination exists, there is a ‘use additional code’ note at the etiology code, and a ‘code first’ note at the manifestation code. These instructional notes indicate the proper sequencing order of the codes, etiology followed by manifestation.”

**Examples** Parkinson’s disease, Alzheimer’s disease, dementia, liver cirrhosis with esophageal varices, and certain infectious organisms including TB, syphilis, diphtheria.

In addition OCG Section I.A.13 explains codes titled “in diseases classified elsewhere.” Codes with this title are a component of the E/M convention. The code title indicates that it is a manifestation code. ‘In diseases classified elsewhere’ codes are never permitted to be used as first-listed or principal diagnosis codes. They must be used in conjunction with an underlying condition code and they must be listed following the underlying condition.
CAUSE AND EFFECT

E/M Convention Does Not Apply to Other Conditions. Conditions and codes outside of the E/M convention are not subject to this rule. Sequencing of all other diagnoses is based on the circumstances of admission and the definition of principal diagnosis, unless there is other authoritative coding direction in the coding classification, OCG, or Coding Clinic advice. Whether any such conditions are manifestations of, etiology of, or “due to” one another plays no role in sequencing.

Further clarification is provided by OCG Section II.B.: “When there are two or more interrelated conditions (such as diseases in the same ICD-10-CM chapter or manifestations characteristically associated with a certain disease) potentially meeting the definition of principal diagnosis, either condition may be sequenced first, unless the circumstances of the admission, the therapy provided, the Tabular List, or the Alphabetic Index indicate otherwise.”

For example, “acute renal failure due to dehydration” does not require you to sequence dehydration (etiology) first as the principal diagnosis, with acute renal failure (manifestation) as an additional diagnosis.

Of course, signs and symptoms of any condition are “manifestations” of that condition. Signs and symptoms related to or routinely associated with an established or confirmed condition are not separately coded at all; therefore, there is no sequencing issue involved.

RELATED CONDITIONS

ICD-10-CM has directions that require a certain code to be assigned when two conditions are related to each other (related conditions). The classification uses several terms to indicate what these associations are including: “with,” “associated with,” and “due to”.

The 2017 Official Guidelines for Coding and Reporting (OCG) provides new guidance in Section I.A.15 (titled “With”):

“The word ‘with’ should be interpreted to mean ‘associated with’ or ‘due to’ when it appears in a code title, the Alphabetic Index, or an instructional note in the Tabular List. The classification
CAUSE AND EFFECT

presumes a causal relationship between the two conditions linked by these terms in the Alphabetic Index or Tabular List. These conditions should be coded as related even in the absence of provider documentation explicitly linking them, unless the documentation clearly states the conditions are unrelated. For conditions not specifically linked by these relational terms in the classification, provider documentation must link the conditions in order to code them as related.”

For example, the index and tabular state that sepsis “with” acute organ dysfunction is assigned code R65.20. If the two are documented in the record, they are assumed to be related and R65.20 is assigned. The tabular also lists examples of acute organ dysfunction, including acute respiratory failure, acute kidney injury, DIC, and encephalopathy—all automatically connected to sepsis if not specified otherwise.

Diabetes “with” complications listed in the classification (e.g., neuropathy, retinopathy, gangrene, gastroparesis) do not need to be linked by the provider. However, the provider will need to document a link-age between osteomyelitis and diabetes before it can be coded as such.

The link between hypertension and heart disease is now assumed as a causal relationship, and the provider no longer has to specify the connection. According to OCG section I.C.9.a:

“The classification presumes a causal relationship between hypertension and heart involvement and between hypertension and kidney involvement, as the two conditions are linked by the term “with” in the Alphabetic Index. These conditions should be coded as related even in the absence of provider documentation explicitly linking them, unless the documentation clearly states the conditions are unrelated.”

If it appears from the record that a related condition might not be due to the other but rather caused by another condition, it is still prudent to seek clarification even though the classification and OCG do not require it.
CMS does not permit providers to submit claims with codes for conditions that cannot be validated or substantiated by the clinical findings, criteria, or circumstances documented in the record. If “clinically invalid” diagnoses are coded on claims that result in improper payments, there can be serious consequences for the hospital.

A main focus of RAC review is the “clinical validity” of codes assigned for documented conditions. CMS requires clinical information in the medical record substantiate a diagnosis based on widely accepted professional diagnostic standards, consensus criteria, clinical practice guidelines, and/or evidence-based medical literature.

As examples, a diagnosis of sepsis cannot be clinically validated without the finding of two or more SIRS criteria. Acute kidney injury would not be a clinically valid diagnosis without having creatinine values or urine output parameters defined by the authoritative KDIGO criteria. Acute respiratory failure must be supported by the well-established blood gas diagnostic standards.

Of course to code any condition the condition must meet the definition of other diagnoses that require “clinical evaluation, or therapeutic treatment, or diagnostic procedures, or increased nursing care/monitoring, or extended length of stay.”

The 2017 OCG contains a new section I.A.19, Code Assignment and Clinical Criteria, that appears to potentially conflict with CMS clinical validation regulations:

“The assignment of a diagnosis code is based on the provider’s diagnostic statement that the condition exists. The provider’s statement that the patient has a particular condition is sufficient. Code assignment is not based on clinical criteria used by the provider to establish the diagnosis.”

This provision may have been intended to clarify that coders should not be responsible for making such clinical distinctions. Coders would not be expected to make clinical validity judgments by
themselves, but organizations must establish clear, compliant policies and processes for dealing with this clinical validation dilemma.

In July 2016, AHIMA published clinical validation advice that included the following:

- Based on CMS guidance, it appears clinical validation may be most appropriate under the purview of the CDI professional with a clinical background.
- The goal of clinical validation is to ensure that the health record is not only coded accurately, but also accurately reflects the clinical scenario within the health record, which requires collaboration among providers, CDI professionals, and coding professionals.
- The importance of accurately capturing the clinical scenario through the available code set continues to grow as CMS revises its payment methodologies, tying quality of care to reimbursement.

Coding Clinic, Fourth Quarter 2016, p. 147, states that the new guideline addresses coding, not clinical validation, and that clinical validation is a separate function from coding. However, clinical validation is essential before codes can be assigned and submitted on claims.

A best-practice, collaborative CDI program that also includes coder education and participation is the solution for addressing clinical validation issues. Medical staff education is necessary as well as support from physician leadership and advisors when needed.

References

- Coding Clinic, First Quarter 2014, p. 11
- Coding Clinic, Fourth Quarter 2016, p. 147.
- CMS MLN Matters SE1121.
- Clinical Validation: The Next Level of CDI. Journal of AHIMA 87, no.7 (July 2016).
2017 CDI Pocket Guide

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