



*ACDIS Answers*

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# Clinical Documentation Improvement FAQs

# **ACDIS Answers: Clinical Documentation Improvement FAQs**

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*ACDIS Answers: Clinical Documentation Improvement FAQs* is published by HCPro, a division of BLR.

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ISBN: 978-1-68308-207-1

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*Editor's Note: This book is a compilation of questions and responses put to ACDIS experts over the past few years. Advice provided is general and information should be vetted with officials at your facility.*

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## **Sharme Brodie, RN, CCDS**

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Allen Frady, RN, BSN, CCDS, CCS, is a CDI educator at HCPro and ACDIS where he teaches clinical documentation improvement boot camps and serves as a subject matter expert for ACDIS. He is an accomplished consultant with a background in coding and documentation. His experience includes 12 years as a coding consultant, two years as a coding director at the Medical College of Georgia, and six years as a CDI consultant. His nursing experience includes work as a case manager and in cardiovascular care in ICU and telemetry.

### ACDIS Advisory Board

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The ACDIS Advisory Board is a multidisciplinary group of professionals whose backgrounds include nurses, providers (physicians, PA, NP), and HIM/coding professionals who provide expertise, CDI best practice direction, and an industry voice for the ACDIS membership and the wider CDI profession with honor and integrity. For more information, visit [www.acdis.org](http://www.acdis.org).

### ACDIS Forum

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The ACDIS Forum is an online networking resource where members of the ACDIS community share their thoughts on CDI best practices.

*Section 1:*  
**Clinical Concepts**



# Diseases and Disorders of the Nervous System

## Past medical history

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*Laurie Prescott, RN, MSN, CCDS, CDIP, CRC*

**Q** If a patient has hypertensive heart disease or cerebrovascular accident (CVA) with hemiparesis in his or her medical history that has not been brought forward in the patient’s medical record for their current inpatient stay, can the coders assign a code for that condition, or does it need to be brought forward by the physical?

**For example, would the physician need to document in the physician assessment that the patient had left-sided hemiparesis?**

**A** The documentation of the hemiparesis would need to be brought forward to the current record. The coders cannot assign codes based on documentation from a previous record. Review the current record closely for any clinical indicators that would prompt a query. For example, the nursing functional assessment within the admission assessment may demonstrate a weakness or paresis. If physical therapy is involved, the therapists’ documentation may provide a clinical indicator to support the query. If such indicators are present, use them to formulate your query.

If the hemiparesis is listed in the past medical history of the history and physical as part of the current patient encounter, you may still need to query the provider. Physicians often describe conditions using the wording “history of,” which can be quite vague, since it could mean either a history of a condition that has resolved or one that remains present.

Due to this very confusion (and frustration on both sides), coders often do not assign a code based on documentation of a past medical history.

## CLINICAL CONCEPTS

Again, review the record for any clues that the condition still exists, as well if it meets the definition of a reportable condition—i.e., did the condition require clinical evaluation, therapeutic treatment, or diagnostic workup, extend the length of that particular patient’s hospital stay during this encounter, or increase nursing care and/or monitoring?

Lastly, in the case of the hemiparesis and CVA, also query for the linkage of the hemiparesis (if found to be present) with the old CVA. This will allow the hemiparesis to be coded as a late effect of the CVA.

*CDI Strategies, August 28, 2014*

### Encephalopathy as integral to seizures/CVA

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*James S. Kennedy, MD, CCS*

**Q** The physician documented “encephalopathy” in the record of a patient who was admitted with a CVA and/or possible seizures. The patient was confused but returned to baseline. Are these conditions considered interrelated, or can we code for the encephalopathy to capture a major complication or comorbidity (MCC)?

**A** Before addressing whether a documented diagnosis of encephalopathy can be coded (and thus affect Medicare Severity diagnosis-related group [MS-DRG] or All Patients Refined diagnosis-related group [APR-DRG] assignment), let’s first clarify several concepts related to ICD-10-CM code assignment and how the CDI processes should work.

**Principal diagnosis:** As you know, according to the ICD-10-CM guidelines and the Uniform Hospital Discharge Data Set, the principal diagnosis is defined as:

*that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.*

## DISEASES AND DISORDERS OF THE NERVOUS SYSTEM

This determination is based on information available at the time of admission, when the physician writes an inpatient order, and is governed by circumstances leading to the need for the physician to order inpatient care. The *Official Guidelines for Coding and Reporting* has clarifying rules governing principal diagnosis assignment, which emphasize the importance of consistent, complete documentation in the medical record. Without such documentation, the application of all coding guidelines is a difficult, if not impossible, task.

**Secondary, additional, or “other” diagnosis:** According to the Uniform Hospital Discharge Data Set (UHDDS), assigning a code for additional conditions that affect patient care require:

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

The UHDDS item 11-b defines other diagnoses 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.*

**CDI processes:** While many definitions exist, CDI is usually defined as the policy, process, and procedure inherent to rendering a physician query and ensuring the integrity of the code assignment. This requires rigorous adherence to ICD-10-CM conventions, *Official Guidelines for Coding and Reporting*, and official advice from the American Hospital Association’s (AHA) *Coding Clinic for ICD-10-CM/PCS* and is exercised when documentation:

- Is conflicting, imprecise, incomplete, illegible, ambiguous, or inconsistent

## CLINICAL CONCEPTS

- Describes (or is associated with) clinical indicators without a definitive relationship to an underlying diagnosis
- Includes clinical indicators, diagnostic evaluation, and/or treatment not related to a specific condition or procedure
- Provides a diagnosis without underlying clinical validation
- Is unclear for present-on-admission indicator assignment

In discussing the coding of encephalopathy, there's a number of issues that should be cleared up first. Note that there is no adjective before the word "encephalopathy" nor any indication of its underlying cause, given that the physician did not link the word "encephalopathy" with any of the other documented conditions.

If we look at the Index to Diseases, there is list of around 100 adjectives or statements of the underlying cause of encephalopathy that require documentation if we are to code to the highest level of specificity. Some of these affect the DRG assignment, such as toxic or metabolic encephalopathy; some of these do not.

Therefore, the first thing to do is query the physician (in a nonleading way) to determine the underlying cause of the encephalopathy. Please refer to the 2013 ACDIS/AHIMA query practice brief [Guidelines for Achieving a Compliant Query Practice](#) for an industry standard in how to accomplish this.

The next challenge is whether the term "encephalopathy" was consistently documented. How many times was the term documented? While there are no published standards, the more often terms are documented, the less likely a recovery auditor or accountable agent is able to remove an ICD-10-CM code from that documentation, especially if it affects reimbursement.

## DISEASES AND DISORDERS OF THE NERVOUS SYSTEM

The next challenge is determining whether the term “possible seizure” should be coded. This question does not provide information related to where the physician documented the term “possible seizure.”

“If the diagnosis *documented at the time of discharge* is qualified as ‘probable,’ ‘suspected,’ ‘likely,’ ‘questionable,’ ‘possible,’ or ‘still to be ruled out,’” or other similar terms indicating uncertainty, code the condition as if it existed or was established, for inpatient admissions, according to the *Official Guidelines for Coding and Reporting*.

The basis for these guidelines are the diagnostic workup, arrangements for further workup or observation, and initial therapeutic approach that corresponds most closely with the established diagnosis.

Since it is unclear whether “possible seizure” was documented at the time of discharge, a query could be deemed necessary to determine if the diagnosis was still valid “at the time of discharge.” If the provider affirms the presence of the “possible seizure” at the time of discharge, we also need to know what the underlying cause of the seizure is (i.e., the current CVA, the late effect of an old CVA, or another cause), whether it is part of a recurrent seizure disorder (i.e., epilepsy), and, if clinically indicated, if it is status epilepticus or part of an intractable seizure disorder.

The next challenge is determining the principal diagnosis for this admission.

*The Official Guidelines for Coding and Reporting* state:

*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.*

## CLINICAL CONCEPTS

As such, we have a seizure (which is a symptom code), a CVA (which is a diagnosis code), and the yet-to-be-determined encephalopathy as potential candidates. My hunch is that the CVA (stroke) will likely be the principal diagnosis, given that this is probably the underlying cause of the “possible seizure” and more than likely required the brunt of the diagnostic workup and treatment rendered. That’s not to say that provider documentation could not provide alternatives. However, explicit documentation at the time of discharge would be necessary to amend this impression.

Let’s say that the physician documented at the time of discharge that the “possible seizure” was due to the CVA but stated that the encephalopathy was due to the seizure and due to the stroke. We’ve determined that the CVA is the principal diagnosis. How should a coder or CDI specialist handle the documentation of the term “encephalopathy” in this situation?

This scenario raises a number of concerns.

**Coding of encephalopathy due to a seizure:** Fortunately, we have official advice on this issue from *Coding Clinic for ICD-9-CM, Fourth Quarter 2013*, which states:

*Question: On admission the patient had mental status changes, which subsequently resolved. Consequently, we determined the patient had encephalopathy secondary to postictal state. Should encephalopathy be reported as an additional diagnosis with seizure when it is due to a postictal state? Would encephalopathy be considered inherent to the seizure or can it be reported separately?*

*Answer: Encephalopathy due to postictal state is not coded separately since it is integral to the condition .... The postictal state is a transient deficit, occurring between the end of an epileptic seizure and the patient’s return to baseline. This period of decreased functioning in the postictal period usually lasts less than 48 hours.*

## DISEASES AND DISORDERS OF THE NERVOUS SYSTEM

With this in mind, we do not add an additional code for encephalopathy because it is due to a seizure.

**Coding of encephalopathy due to a CVA:** This is dicey, given that there is no uniform definition for the word “encephalopathy.” However, [\*an ACDIS white paper on altered mental status published in 2008\*](#) may help provide some background. Does the term “encephalopathy” mean “any disease of the brain,” as its etymology would suggest, or is it a diffuse brain disease resulting in global brain dysfunction, as suggested by the [\*National Institutes of Health in their paper?\*](#)

When is the term “encephalopathy” integral to the defined brain disease, such as Alzheimer’s disease, multiple sclerosis, or a dementia as the late effect of multiple strokes?

*Coding Clinic for ICD-9-CM, Fourth Quarter 2003, states:*

*Prior to October 1, 2003, several types of encephalopathy were all coded to 348.3, Encephalopathy, unspecified. New codes have been created to uniquely identify metabolic encephalopathy (348.31). Prior to this change, metabolic encephalopathy was indexed to delirium and coded to category 293, Transient organic psychotic conditions.*

*Metabolic encephalopathy is always due to an underlying cause. There are many causes of metabolic encephalopathy, such as brain tumors, brain metastasis, cerebral infarction or hemorrhage, cerebral ischemia, uremia, poisoning, systemic infection, etc. Metabolic encephalopathy is also a common finding in 12–33% of patients suffering from multiple organ failure. The development of metabolic encephalopathy may be the first manifestation of a critical systemic illness and may be caused by various reasons—one of the most important being sepsis.*

## CLINICAL CONCEPTS

In summary, CDI specialists need to consider how documented conditions are defined, identify the essential components of the documented conditions, and how coding conventions, *Official Guidelines for Coding and Reporting*, or official *Coding Clinic* advice address these conditions.

The ICD-10-CM/PCS conventions do not always define what conditions are “integral” within the code set nor how Recovery Auditors may view the issue.

When considering if a diagnosis is integral to a condition, I typically ask myself whether most patients with this condition experience this symptom or diagnosis or what the literature may say about it. No matter what I think, however, the documenting provider has to make the call and then I have to determine whether I can defend his or her answer if challenged by an auditor or other accountability agent.

- Bottom line: When in doubt, query the provider to further clarify the situation. As such, I would query along the following issues:
- Whether the uncertain diagnosis of seizure should be coded
- What the nature, severity, repetitiveness, and underlying cause of the seizure is likely to be
- What adjective best describes the documented encephalopathy or what the underlying cause of the encephalopathy is
- Whether the documented encephalopathy is integral to the CVA or seizure

The final coding of this record depends upon provider documentation and the coder’s comfort in assigning the code, which is an entirely different discussion we need to have since it is the coder’s initials that go on the coding sheet, not the CDI specialist’s.

*CDI Strategies, January 22, 2015*

## Defining ‘subacute’

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Laurie Prescott, RN, MSN, CCDS, CDIP, CRC

**Q** The primary physician documented subacute cerebral infarction, and I am wondering whether I should code this to a new CVA or not since the term “subacute” doesn’t really fall anywhere.

**A** The *Official Guidelines for Coding and Reporting* offers no definition as to what is considered acute, subacute, or chronic. I have found subacute to mean something in between acute and chronic, which is a vague description at best! For questions such as this, I refer to the AHA’s *Coding Clinic for ICD-10-CM/PCS* for assistance. *Coding Clinic*, First Quarter 2011, p. 21, states:

*Question: How is the diagnosis documented as “subacute deep vein thrombosis (DVT) code? There are index subentries for acute and chronic, but not for subacute?*

*Answer: Assign code 45.39, acute venous embolism and thrombosis of other specified veins, for a diagnosis of subacute DVT.*

Now, this reference does not specifically describe a CVA but does offer guidance that the term subacute is interpreted as being acute. But I would like to see more guidance related to CVA. So let’s look at *Coding Clinic*, Second Quarter 2013, p. 10:

*Question: The patient suffered a subacute ischemic right posterior watershed infarct with small focus of subacute hemorrhage. How should this be coded?*

*Answer: Assign 434.91 Occlusion of Cerebral arteries, cerebral artery occlusion, unspecified with cerebral infarction AND 431 Intracerebral hemorrhage, for the description subacute ischemic right posterior parietal watershed infarct with small focus of subacute hemorrhage.*

## CLINICAL CONCEPTS

*In this instance the patient had an ischemic stroke as well as a hemorrhagic stroke.*

Although this *Coding Clinic* addresses the fact that two codes would be assigned because there was both an ischemic and hemorrhagic stroke, it also reinforces that the wording of subacute would apply to the codes for a CVA versus codes for a history of CVA. *Coding Clinic* offers much guidance when we encounter those “gray” areas of the code set and should be the reference that you seek in such situations.

*CDI Strategies, October 9, 2014*

### **DRG 067 and 068; nonspecific CVA and precerebral occlusion without infarct**

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*Laurie Prescott, RN, MSN, CCDS, CDIP, CRC*

**Q** What exactly are DRG 067 and 068, nonspecific CVA and precerebral occlusion without infarct? How is it different than transient ischemic attack (TIA) or CVA?

**A** DRGs assist us in classifying patients into one of the more than 700 different groups depending upon the identified principal diagnosis (reason for admission) and any secondary diagnoses identified as complications and comorbidities. The performance of a procedure can also influence the DRG assignment. The conditions grouped in each MS-DRG category are expected to require the same level of hospital resources. Thus your organization is paid a flat fee that is assigned to the specific DRG grouping.

Each DRG has a list of specific diagnoses contained within that grouping. DRG 067 and 068 are two of the three diagnostic groupings that encompass admissions related to TIAs and occlusion or stenosis of precerebral and cerebral arteries. Others include:

## DISEASES AND DISORDERS OF THE NERVOUS SYSTEM

- DRG 067/068: assigned for patients admitted with the diagnoses related to an occlusion and stenosis of precerebral or cerebral arteries, not resulting in a cerebral infarction.
- DRG 69: assigned for an admission for a TIA; there are 13 different diagnoses that map to this DRG that differ related to the location of the TIA.
- DRGs 061, 062, 063: assigned to patients admitted with a cerebral infarction and receives administration of thrombolytics.
- DRGs 064, 065, 066: assigned to patients with a cerebral infarction and thrombolytics were not administered at that facility.

*CDI Strategies, June 23, 2016*

## Principal diagnosis assignment for UTI versus encephalopathy

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*Cheryl Ericson, MS, RN, CCDS, CDIP*

**Q** How should the diagnosis of urinary tract infection (UTI) and encephalopathy be sequenced, specifically which diagnosis should be the principal? If physician documentation indicates that the patient came in with confusion, can encephalopathy be assigned as the principal diagnosis if it is due to the UTI and no other contributing issues are present?

**A** Assigning the UTI as the principal diagnosis makes the claim more vulnerable to denial than the encephalopathy does. If you look at the big picture, a UTI does not support inpatient care. Additionally, there is no coding rule that requires the UTI to be coded as the principal diagnosis because it is not part of an etiology/manifestation pair. According to the UHDDS definition of the principal diagnosis, it is the condition (after study) that occasioned the admission.

## CLINICAL CONCEPTS

The inclusion of the term “after study” is often what throws off accurate principal diagnosis assignments, because people don’t look at the totality of the coding guidelines. At times, symptoms present at the time of admission require further “study” in order for the physician to find a definitive diagnosis.

Symptoms may be reported when no other definitive diagnosis can be identified, but this this leads to assignment of a lower-weighted MS-DRG, less specificity in assignment, and a vague medical record overall. So, the preference is to avoid reporting symptoms as a principal diagnosis.

For example, the provider often describes encephalopathy instead of diagnosing it, documenting the patient as having altered mental status. If the patient has encephalopathy, they usually need inpatient care, not just supportive care, because the goal is to stop the progression of the encephalopathy by finding and treating the cause.

When looking at the record, think about the patient’s continuum of care. Ask yourself, at what point is the patient safe for discharge? In this case, would it be when the physician treats the encephalopathy or the UTI? Clinically speaking, this patient would be safe to discharge when he or she returns to baseline in mental functioning, not when the UTI is resolved.

A UTI (even a complicated one) can be treated in the outpatient setting. Also, look at the totality of the record: Was the focus of the treatment the “altered mental status” (was a CT scan performed, etc.) or was it on a UTI?

Not every patient with a UTI has encephalopathy. However, if they are sick enough to need inpatient care, they likely have more going on.

## DISEASES AND DISORDERS OF THE NERVOUS SYSTEM

Encephalopathy also isn't as big of an audit target as UTIs. Yes, auditors do deny encephalopathy claims since it is an MCC—but so is severe malnutrition, acute respiratory failure, etc. Think about what type of claim is usually more vulnerable.

When the UTI is the principal diagnosis and encephalopathy is the MCC, there is only one MCC in the record. When encephalopathy is the principal diagnosis, the UTI can be added as a CC.

When the encephalopathy is a principal diagnosis, auditor denials are not the issue; the real concern is with the documentation not supporting it as a reportable condition. When encephalopathy is documented, we must evaluate clinical validity. Ask:

- “How is the patient’s mental status different from baseline?”
- “Is this an acute confusion?”
- “Is there acute infective psychoses?”
- “What efforts lead to improved mental status?”

*CDI Strategies, March 19, 2016*

# ACDIS Answers

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# Clinical Documentation Improvement FAQs

This compendium of commonly asked CDI questions is an essential reference book and office companion, valuable for new CDI specialists as well as those experienced in concurrent medical record review. Whether you're wondering about sequencing guidelines, staff productivity, escalation policies, diabetes coding, or documentation requirements for acute kidney injury, **ACDIS Answers** provides quick, easily understandable information from respected experts in CDI, including ACDIS' own Boot Camp instructors and Advisory Board members.

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