Anemia

The ICD-10 Success Series
Webconference
December 3, 2014
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Use the GoTo Webinar Question Panel to Ask a Question

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Managing Your Screen

To minimize the control panel

Click the orange button with the white arrow

Minimizes the control panel to the right side of your screen

Re-opens the control panel

To maximize the presentation area

The blue button with the white square will maximize the presentation to fill your screen
Across the coming months, the Advisory Board’s Clinical Advisor Team will be hosting numerous Webconferences on a variety of documentation topics critical to a seamless and successful transition to ICD-10. As providers, please take a look at the list of upcoming sessions and save time to attend those most pertinent to your practice. We have created them to be succinct and to the point, and will be presenting lessons you can begin to incorporate into your documentation immediately (in an ICD-9 world). Below is a list of all upcoming sessions:

1. September 24th – Sepsis/Septicemia
2. October 1st – UTI
3. October 8th – Pressure Ulcers
4. October 15th – Stroke
5. October 22nd – Encephalopathy
6. October 29th – AMI & Coronary Artery Disease
7. November 5th – Respiratory Failure, Pneumonia, COPD
8. November 12th – Orthopedic Surgery, Joints, Spine
9. November 19th – Diabetes
10. December 3rd – Anemia
11. December 10th – Cellulitis
12. December 17th – Ambulatory

**All sessions will be hosted from 12:00 – 1:00 pm EST. Recordings will be made available for follow up viewing on the intranet and physician websites.**
About Today’s Speaker

Dan Avstreih, MD FACEP

- Senior Medical Director at the Advisory Board Company
- Board certified physician in Emergency Medicine
- Since 2006, Dr. Avstreih has practiced at an ultra high-volume, tertiary care/level 1 trauma emergency department in Northern Virginia
- Dr. Avstreih holds clinical professor appointments at both the Virginia Commonwealth School of Medicine and the George Washington University School of Medicine
- Dr. Avstreih is an Associate Medical Director of the largest fire-rescue department in Virginia, overseeing the emergency medical care of more than 1.1 million citizens
- Serves in emergency management roles for both Northern Virginia and the National Capital Region.

For more information, contact:

Dan Avstreih, MD, FACEP
Senior Medical Director

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Brief Overview: Code Expansion in ICD-10 Requires Greater Documentation Specificity

Expanded Code Set in ICD-10: ~16K to ~150K

Why So Many New Codes?

The main difference between ICD-9 and ICD-10 codes, outside of structural changes, is the SPECIFICITY of the code.

ICD-10 codes specify several components not found in ICD-9, such as stage, laterality, severity, root cause operation, etc.

Key ICD-10 Concepts Required in Documentation

<table>
<thead>
<tr>
<th>Stage or grade of disease</th>
<th>Severity: mild, moderate, severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specific anatomical location</td>
<td>Episode of care: initial vs. subsequent</td>
</tr>
<tr>
<td>Acute or chronic</td>
<td>Unilateral or bilateral condition</td>
</tr>
</tbody>
</table>
Road Map for Discussion

1. Documentation Requirements for Anemia in ICD-10
2. Clinical Scenario
3. Upcoming Webconferences
# Anemia

## ICD-10-CM Documentation Concepts

<table>
<thead>
<tr>
<th>Documentation Concepts</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Acuity</strong></td>
</tr>
<tr>
<td>• Acute</td>
</tr>
<tr>
<td>• Chronic</td>
</tr>
<tr>
<td><strong>2. Type</strong></td>
</tr>
<tr>
<td>• Nutritional Anemia <em>(e.g. iron deficiency, vitamin B12 deficiency, Folate, other, unspecified)</em></td>
</tr>
<tr>
<td>• Hemolytic Anemia</td>
</tr>
<tr>
<td>• Enzyme disorders <em>(e.g. glutathione metabolism, glycolytic enzymes)</em></td>
</tr>
<tr>
<td>• Thalassemia <em>(e.g. alpha, beta, delta-beta, minor)</em></td>
</tr>
<tr>
<td>• Sickle Cell</td>
</tr>
<tr>
<td>• Aplastic and Other Anemias</td>
</tr>
<tr>
<td><strong>3. Etiology</strong></td>
</tr>
<tr>
<td>• Post hemorrhagic</td>
</tr>
<tr>
<td>• Drug induced <em>(autoimmune or non-autoimmune)</em></td>
</tr>
<tr>
<td>• Chemotherapy/Immunotherapy/Radiation</td>
</tr>
<tr>
<td>• Malignancy</td>
</tr>
<tr>
<td>• Manifestation of an adverse effect or poisoning</td>
</tr>
</tbody>
</table>

Is the anemia secondary to hemorrhage associated with a procedure? 
If so, documentation should specify if it was a Complication or Expected Outcome.
# Aplastic Anemia/ Pancytopenia

Specificity Impacts Severity of Illness

<table>
<thead>
<tr>
<th>Condition</th>
<th>Documentation Concept</th>
<th>Specified Options</th>
</tr>
</thead>
</table>
| Aplastic Anemia| Document **type** and **etiology** | • Constitutional  
• Drug–induced  
• Due to other external agents  
• Idiopathic  
• Other  
• Unspecified |
| Pancytopenia   | Document **etiology** (“due to”) | • Antineoplastic chemotherapy induced  
• Other drug-induced  
• Other |
Examples: Linking Diseases

- Anemia due to antineoplastic chemotherapy
- Aplastic anemia due to antineoplastic chemotherapy
- Anemia due neoplastic disease (malignancy)

Use terms like “due to” or “with”

Note: Lists, commas, and the word “and” do not link conditions
A Deeper Dive: Acute Blood Loss Anemia

Acute Blood Loss Anemia, When Present, is a Major Severity Driver

Acute Blood Loss Anemia: Opportunity to Clarify

• Acute Blood Loss Anemia presents a frequent documentation improvement opportunity across the country.

• There is no clear clinical definition for acute blood loss anemia. Considerations include:
  ✓ Drop in Hgb/HCT
  ✓ Increased monitoring of lab values (more than the routine)
  ✓ Hypotension
  ✓ Shortness of Breath
  ✓ Other symptoms such as tachycardia, inability to participate in PT or other therapies
  ✓ PO or IV iron preparations
  ✓ Need for Blood transfusion (transfusion is not required)

• The bottom line: it’s up to your clinical judgment as the physician!
**Secondary Diagnosis:** all other conditions, either present on admission or that develop subsequently, may qualify as secondary diagnoses if they affect patient care.

"What conditions affect patient care during the admission, in addition to the primary (principal) diagnosis?"

Document all conditions that affect the hospital care in terms of **any one of the following:**

- Clinical evaluation,
- Therapeutic treatment,
- Diagnostic procedure,
- Increased nursing care/monitoring, and/or
- Extended LOS

**Note:** Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded.
Documentation of Procedural Complications

Procedure notes should reflect any of the following regarding complications

Reminders:
- Often times the terms “post-surgical, post-procedural or post-operative” are a time stamp and not a complication of care. When this is the case, ensure it is clear in your documentation. Consider using language such as “expected post-operative anemia, blood loss within normal limits.”
- Acute blood loss anemia is not a Patient Safety Indicator (PSI)
- When documentation within the record is unclear, it is advised that the physician be queried.

<table>
<thead>
<tr>
<th>Timing</th>
<th>Intraoperative</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Postprocedure</td>
</tr>
<tr>
<td></td>
<td>Late effect</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Aspiration, puncture, other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Endoscopic exam</td>
</tr>
<tr>
<td></td>
<td>Infusion, transfusion, injection</td>
</tr>
<tr>
<td></td>
<td>Removal of a catheter or packing</td>
</tr>
<tr>
<td></td>
<td>Medical procedure – Name It</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Associated with</th>
<th>Accidental puncture/laceration</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Same or different system</td>
</tr>
<tr>
<td></td>
<td>Blood products</td>
</tr>
<tr>
<td></td>
<td>Central venous catheters</td>
</tr>
<tr>
<td>Drugs</td>
<td>What adverse effect</td>
</tr>
<tr>
<td></td>
<td>Drug name</td>
</tr>
<tr>
<td></td>
<td>Correctly prescribed</td>
</tr>
<tr>
<td></td>
<td>Properly administered</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Encounter</th>
<th>Initial</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Subsequent</td>
</tr>
<tr>
<td></td>
<td>Sequelae</td>
</tr>
</tbody>
</table>
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Clinical Scenario:

**H&P:** Admit, s/p fx femur. Plan ORIF after cleared. Consult Medicine: P.O.D #1. S/P ORIF femur (EBL 500).

**PN:** P.O.D day 1. HGB 6.2. Anemia. Plan: Transfuse 2 u PRBCs.

**PN:** P.O.D day 2. HGB 8.2 after transfusion. Will monitor. Add PO iron. Pt is up with assist due to dizziness.

Scenario 1
- Documentation contains:
  - Anemia

Scenario 2
- Documentation contains:
  - Acute blood loss anemia

<table>
<thead>
<tr>
<th>Scenario</th>
<th>MS-DRG</th>
<th>Description</th>
<th>Weight</th>
<th>GMLOS</th>
<th>Exp. Mort. Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>482</td>
<td>Hip and Femur Procedures except Major Joint w/o CC or MCC</td>
<td>1.6305</td>
<td>3.9</td>
<td>0.3%</td>
</tr>
<tr>
<td>2</td>
<td>481</td>
<td>Hip and Femur Procedures except Major Joint w/ CC</td>
<td>1.9721</td>
<td>4.8</td>
<td>0.6%</td>
</tr>
</tbody>
</table>
Clinical Scenario:

73 y/o presents with failed outpatient treatment of UTI with Bactrim. Signs and symptoms include fatigue, hematuria and persistent UTI. Labs: WBC 2.1, hgb 8.1 and platelets 55. Impression – UTI, anemia-discontinued Bactrim

Scenario 1
- Documentation contains:
  - UTI
  - Anemia

Scenario 2
- Documentation contains:
  - UTI
  - Drug-induced aplastic anemia

<table>
<thead>
<tr>
<th>Scenario</th>
<th>MS-DRG</th>
<th>Description</th>
<th>Weight</th>
<th>GMLOS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>690</td>
<td>Kidney &amp; urinary tract infections w/o MCC</td>
<td>0.7693</td>
<td>3.2</td>
</tr>
<tr>
<td>2</td>
<td>689</td>
<td>Kidney &amp; urinary tract infections w/ MCC</td>
<td>1.1300</td>
<td>4.3</td>
</tr>
</tbody>
</table>
Specify Diagnosis Rather Than a Sign or Symptom

**Clinical Scenario:** Patient is a 65 year-old white female who was admitted for a right total hip replacement. Her past medical history includes chronic kidney disease. Pre-operative Labs: WBC 14.1, RBC 3.77, Hgb 13.2, HCT 30, BUN 23, Creatinine 1.6, GFR 32. Post operative labs: WBC: 13.4, RBC: 3.89, Hemoglobin: 8.6, Hematocrit: 25.0, Platelets: 160K, BUN: 24, Creatinine: 1.7, eGFR 33. Estimated blood loss with 800cc. She was transfused with 3 units of PRBC and H/H was monitored.

**Common Insufficient Documentation**
- PDx: osteoarthritis in hip joint.
- Procedure: total hip arthroplasty
- Drop in H/H
- CKD stable @ baseline

**Best Practice Documentation**
- PDx: unilateral primary osteoarthritis right hip
- Procedure: right total hip arthroplasty
- Acute posthemorrhagic anemia
- CKD Stage 3

**Documentation Teaching Point:**
The use of lab values to describe a diagnosis cannot be coded; it is necessary for the physician to document the actual diagnosis.
Signs, Symptoms, and Diagnoses

Key Definitions

**Sign:** an objective evidence of disease observed by examining the patient

**Symptom:** a subjective observation reported by the patient

**Diagnosis:** a statement of conclusion that describes the reason for a disease, illness or problem

Why is this relevant?

- Misperceptions associated with the coding of signs and symptoms are a common source of coding errors.
- The coding guidelines discourage assigning codes for signs and symptoms instead of a diagnosis.
- The terms *possible, probably, likely or suspected* are acceptable in the inpatient setting.
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Upcoming Webconferences

Through the ICD-10 Success Series, The Valley Hospital will have access to multiple Webconferences that cover a range of ICD-10 Documentation Topics. Please make time to attend topics pertinent to your practice!

**Upcoming Sessions:**

- December 10\(^{th}\) – Cellulitis
- December 17\(^{th}\) – Ambulatory

*Please reach out to John McConnell, mccojo@valleyhealth.com if you need assistance registering.*

*All sessions are from 12-1pm EST*
CME Survey

https://www.surveymonkey.com/s/ICD10-Anemia
Questions?

Please do not forget to fill out your CME Survey Link!