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THE LIVANTA CLAIMS REVIEW ADVISOR

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Higher-Weighted Diagnosis Related Groups (HWDRG) Validation – Anemia and GI Bleeding

This month's issue of *The Livanta Claims Review Advisor* addresses the assignment of the principal diagnosis when a patient is admitted for both gastrointestinal (GI) hemorrhage (also called GI bleeding) and anemia, as well as assignment of the correct codes for both conditions. Livanta finds during HWDRG reviews that hospitals frequently re-sequence anemia to the principal diagnosis in place of the hemorrhage code, or they add a complication or comorbidity (CC) of acute blood loss anemia without supporting documentation. The case scenarios offered in this edition are intended to provide hospital staff with information concerning the guidelines associated with these two common diagnoses.

Types of Anemia

Documenting the type, etiology, and chronicity of anemia can often make a difference in reimbursement, although not necessarily in an expected way. For example, in cases where anemia due to chronic kidney disease caused the admission and was the only focus of care, the principal diagnosis would be chronic kidney disease. Also, anemia due to a malignancy is sequenced differently from anemia due to chemotherapy. Those seemingly small details can make a big difference in diagnosis-related group (DRG) assignment. More than 100 diagnosis codes are available for anemia. The table below shows ten of the most common anemia diagnosis codes. Many anemia code categories offer a higher level of specificity than what is listed below.

Diagnosis Code	Diagnosis
D50.0	Chronic or unspecified blood-loss anemia
D62	Acute posthemorrhagic anemia
D61.9	Aplastic anemia NOS
D63.0	Anemia in neoplastic disease
D63.1	Anemia in chronic kidney disease
D64.81	Anemia due to chemotherapy
D61.810	Pancytopenia due to chemotherapy
D59.9	Acquired hemolytic anemia NOS
D57.1	Sickle-cell disease NOS w/o crisis
D53.9	Nutritional anemia NOS

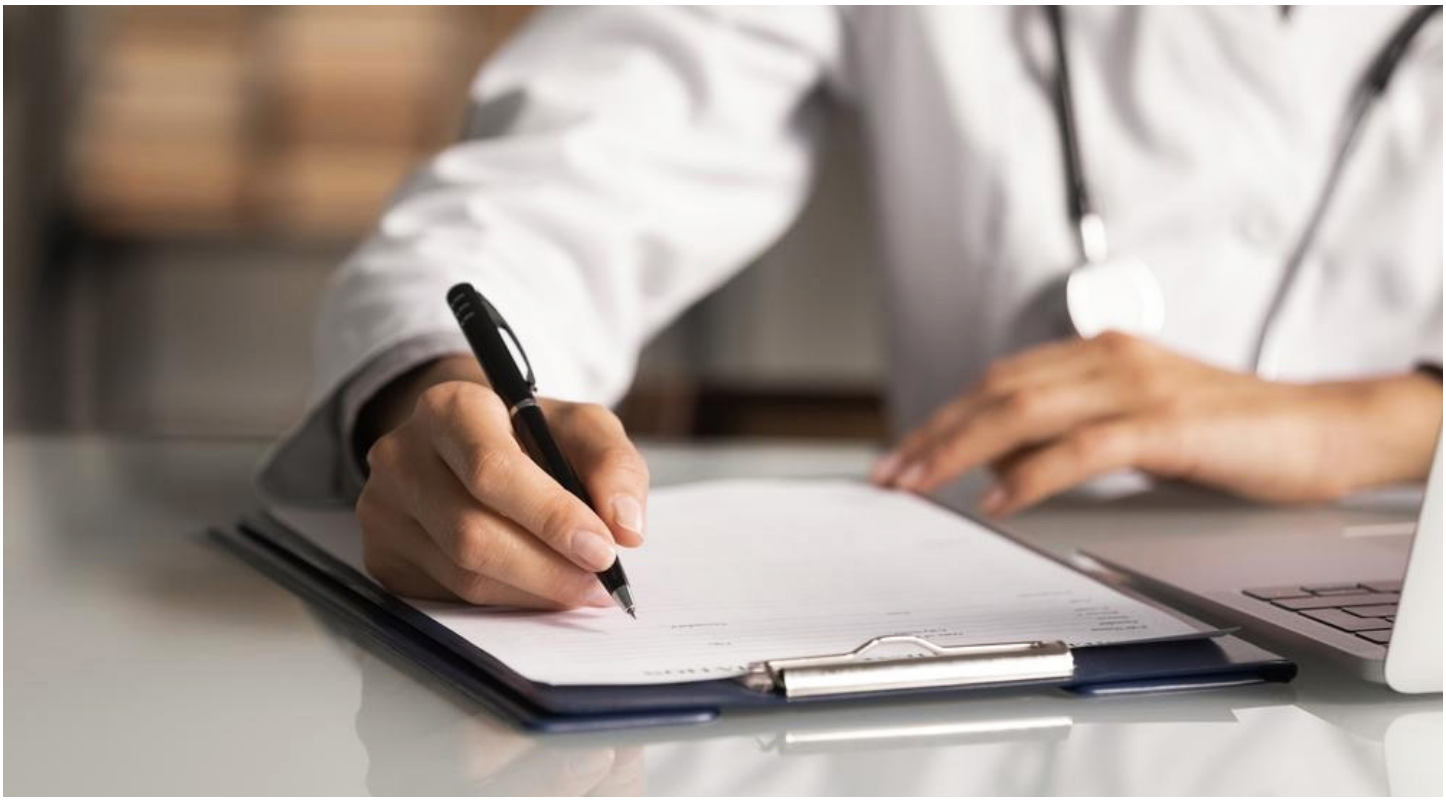
Coding Guidelines for Anemia

- If both acute and chronic blood loss anemia are documented, assign only the code for acute blood loss anemia *(AHA Coding Clinic Third Quarter 2019)*.
- For aplastic anemia and neutropenic fever due to chemotherapy, assign four codes: D61.810 (chemotherapy induced pancytopenia); D70.1 (agranulocytosis due to (d/t) chemo); R50.81 (fever d/t conditions classified elsewhere); and T45.1X5A (adverse effect of chemo) *(AHA Coding Clinic Third Quarter 2020)*.
- For sickle-cell disease, the documentation should include the type (Hb-SS, Hb-C, thalassemia, other), as well as any complications (cerebrovascular involvement, acute chest syndrome, splenic sequestration, with crisis and other complication, with crisis NOS, without crisis.)

Coding Guidelines for GI Bleeding/Hemorrhage

- Arteriovenous malformation of the stomach or bowel NOS is reported as acquired angiodysplasia, rather than congenital as the index indicates *(AHA Coding Clinic Third Quarter 2018, page 21)*.
- For gastrointestinal hemorrhage where GI ulcer, gastritis, duodenitis, diverticulosis, varices, and/or angiodysplasia are present without evidence of current bleeding, assign all GI codes as “with hemorrhage” because the classification presumes a causal relationship between the listed conditions and GI bleeding *(AHA Coding Clinic Third Quarter 2018, page 21)*.

Documentation Good Practices



- Describe the clinical signs and symptoms (dizziness, orthostatic hypotension, fatigue, pallor, whether the blood is bright red versus having a coffee ground appearance, etc.)
- Document all work-up, including colonoscopy, esophagogastroduodenoscopy (EGD), complete blood count (CBC), etc.
- Document the source of the bleeding, if known (gastritis, angiodysplasia, stomach ulcer, diverticular disease, colon polyp, hemorrhoids, etc.). If the source is not known, document the suspected source, including enough information to support that probability.
- Document any treatment rendered for both anemia and GI hemorrhage.
- Document the presence or absence of blood-loss anemia. If present, document whether it is acute or chronic.

Principal Diagnosis Assignment

The primary determinant of the correct principal diagnosis in patients admitted with both a GI hemorrhage and resultant anemia is related to the condition that used more hospital resources. Both conditions often cause admission, and many would say that they are interrelated. But if the hemorrhage was treated and/or evaluated with one or more endoscopy procedures, and the anemia was treated with blood transfusion(s), the hemorrhage is considered to be the focus of care, as it used more hospital resources. This guidance comes from AHA Coding Clinic Fourth Quarter 1990, page 20-24, Example # 8. The article explains that when an endoscopy is performed, the focus of care is the identification and/or treatment of the source of the bleeding.

Additionally, according to the Official Coding Guidelines, 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.” Notice that this rule mentions the therapy provided. It means that if more resources are used for one condition as compared to the other, the condition requiring the higher level of care should be sequenced first.

Case Scenarios for Anemia and GI Bleed

Case Review Summary #1 – The Principal Diagnosis Is Incorrect: The patient was admitted with coffee-ground emesis and a hemoglobin level of 6.2 g/dL. The patient was taken to the endoscopy suite for an EGD. She was found to have an acute gastric ulcer with bleeding. The ulcer was treated with cautery. Because of her low hemoglobin, the patient was transfused with two units of packed red blood cells. Once her hemoglobin stabilized and there was no further bleeding, the patient was discharged with a diagnosis of acute blood-loss anemia due to bleeding gastric ulcer. The case was initially billed with the ulcer as the principal diagnosis, and then rebilled with the anemia sequenced first. After review, Livanta determined that the bleeding ulcer was the correct principal diagnosis because it was the primary focus of care and required the use of more hospital resources compared to the anemia.

Case Review Summary #2 – Anemia Type Was Not Clinically Supported: The patient was admitted with exacerbation of his chronic obstructive pulmonary disorder (COPD). He had a known history of hypertension, coronary artery disease (CAD), chronic gastritis, and anemia. The patient's hemoglobin was 9.5 g/DL and he was started on oral iron supplements. He was discharged with these same diagnoses. A post-discharge physician query was submitted to determine the type of anemia. The physician answered that the patient had acute blood-loss anemia. The claim was resubmitted with acute blood-loss anemia as the only CC. The case was referred to one of Livanta's physician reviewers for clinical validation of acute blood-loss anemia. The physician reviewer's determination was that this diagnosis was not clinically valid because there was no documentation or clinical evidence of an acute hemorrhage.

Case Review Summary #3 – Diagnosis Was Not Supported by Documentation: The patient was admitted for acute cholecystitis that was surgically treated with a laparoscopic cholecystectomy. The patient's preoperative hematocrit was 40 percent. Routine labs showed that this number had dropped to 33 percent postoperatively. The drop in hematocrit was not mentioned by the attending physician and was not coded initially. After discharge, a query was submitted asking for the diagnosis associated with this lab result. The attending physician answered, "This was an insignificant drop in hematocrit." As a result, R71.0 (drop in hematocrit) was added as the only CC and the claim was rebilled. However, because the attending physician stated that it was insignificant, the code was not reportable. This is per the Official Coding Guidelines, Section III.B, which states that abnormal findings are not reported unless the provider indicates their clinical significance.

Case Review Summary #4– Link Between Hemorrhage and GI Condition Not Coded Correctly: The patient was admitted for treatment of COPD exacerbation. He had a past medical history (PMH) of hyperlipidemia, chronic gastritis, hypertension, and congestive heart failure (CHF). On day two of his four-day stay, the patient had a single episode of melena. Because of this, a daily complete blood count (CBC) was obtained, and these numbers were normal. The discharge diagnoses included: exacerbation of COPD, melena, hyperlipidemia, hypertension, chronic gastritis, and CHF. The hospital initially submitted the claim without the CC of melena, so it was resubmitted with this diagnosis added. However, because the patient had a known diagnosis of chronic gastritis, the melena should have been combined with the gastritis. Doing so results in K29.51, chronic gastritis with hemorrhage, and this code is a major complication or comorbidity (MCC). Livanta recommended this change and the resulting MCC-driven DRG. The automatic link is supported by *Coding Clinic Third Quarter 2018, page 21*.

Focused Training

Based on HWDRG claim reviews conducted by Livanta, many hospitals could benefit from focused training on the proper documentation and coding of anemia and gastrointestinal hemorrhage, especially when they occur together. Accurate coding based on the coding guidelines and supported by thorough documentation in the medical record ensures proper claim submission and payment.

Please contact Livanta at Claimreview@Livanta.com if your hospital is interested in focused training on this or other coding topics.

About Livanta

Livanta is the national Medicare Claim Review Services contractor under the Beneficiary and Family Centered Care – Quality Improvement Organization (BFCC-QIO) Program. As the Claim Review Services contractor, Livanta validates the DRG on hospital claims that have been adjusted to pay at a higher weight. The adjusted claim is reviewed to ensure that the diagnoses, procedures, and discharge status of the patient reported on the hospital's claim are supported by the documentation in the patient's medical record. Livanta's highly trained credentialed coding auditors adhere to the accepted principles of coding practices to validate the accuracy of the hospital codes that affect the DRG payment. When needed, actively practicing physicians review for medical necessity and clinical validity based on the presence of supporting documentation and clinical indicators.

Post-payment review of these HWDRG adjustments is mandated under statute and in the Centers for Medicare & Medicaid Services (CMS) QIO Manual: Perform DRG validation on prospective payment system (PPS) cases (including hospital-requested higher-weighted DRG assignments), as appropriate (see §1866(a)(1)(F) of the Act and 42 CFR 476.71(a)(4)).

Read more: CMS, Quality Improvement Organization Manual, Chapter 4 - Case Review
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/qio110c04.pdf

Questions?

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