Hospital Utilization Review Quarterly Stakeholder Meeting

Office of Inspector General Investigations and Reviews Division Surveillance Utilization Review

January 23, 2023

Purpose and Disclaimer

Purpose:

To promote dialogue regarding Hospital Utilization Review between and among the attendees. The group will meet periodically to discuss utilization review and obtain stakeholder input.

Disclaimer:

The discussions at these stakeholder meetings are for informational purposes only and are not binding on the Health and Human Services Commission Office of Inspector General, Medicaid and CHIP Services, or its representatives.

Introduction

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Discussion Points Today

Clarify documentation inconsistencies pertaining to coding specific and non-specific diagnosis and procedure codes.

- Resolved Conditions
- Anemia Complicating - Pregnancy
- Obesity Complicating - Pregnancy
- Unspecified Diagnoses with Specified Diagnoses
- Sequencing of Procedure Codes
- Newborn Circumcisions During and After Birth

Resolved Conditions Coding Guidelines: Previous Conditions

- If the provider has included a diagnosis in the final diagnostic statement, such as the discharge summary or the face sheet, it should ordinarily be coded.
- Some providers include in the diagnostic statement: resolved conditions, diagnoses, status post procedure from a prior admission .
- Conditions having no bearing on the current stay should not be reported.

Resolved Conditions

- The physician notes the patient completed treatment for a UTI three weeks ago. The patient's symptoms have resolved, and the physician is not evaluating the condition. This is a notation of a resolved condition; it should not be assigned as an additional code.

- The physician notes the patient completed antibiotics for a UTI but is still experiencing dysuria. The physician orders a urinalysis and gives the patient another antibiotic prescription for UTI treatment . In this case, the condition is documented as current and is being actively treated. An additional code should be assigned.

Resolved Conditions

American Hospital Association's Coding Clinic from the Third Quarter of 2007 states:

Chronic conditions such as, but not limited to, hypertension, Parkinson's disease, COPD, and diabetes mellitus are chronic systemic diseases that ordinarily should be coded even in the absence of documented intervention or further evaluation.

Anemia Complicating Pregnancy
Anemia of the Puerperium/Postpartum

- Must be specified by the physician along with the type (acute blood loss, iron deficiency).

- A diagnosis code for postpartum anemia should not be used based exclusively on the lab values or because the patient had a blood transfusion. It must be based on the physician's documentation.

Obesity Complicating Pregnancy

- If the physician documented "obesity complicating pregnancy," Code O99.214, Obesity complicating childbirth would be coded, however it would be unnecessary to code E66.9, Obesity, unspecified as it is not a specific code.

- Code O99.214 already has "obesity" within the combination code. Had the physician documented "morbid obesity," then code E66.01, Morbid obesity would be added as a specific code.

Unspecified Codes with Specific Codes

Question

- If an obstetric patient is admitted and delivers, and the physician documents "obstetric patient delivered with anemia," should both code O99.02 Anemia complicating childbirth and D64.9, Anemia, unspecified be coded or should only O99.02 be assigned?

Unspecified Codes with Specific Codes

Answer

Only code O99.02, Anemia complicating childbirth should be assigned. Even though the tabular states *"Use additional code to identify specific condition."*

- Note the word *"specific"* in the documentation. The unspecified anemia is not a specific type of anemia, so an additional code would NOT be assigned. Had the physician documented "iron deficiency anemia" then code D50.9, Iron deficiency anemia would have been coded since this is a specific type of anemia.

Selection of Principal Procedure I

- Procedure performed for definitive treatment of both principal diagnosis and secondary diagnosis
- Sequence procedure performed for definitive treatment most related to principal diagnosis as principal procedure.

Selection of Principal Procedure II

- Procedure performed for definitive treatment and diagnostic procedures performed for both principal diagnosis and secondary diagnosis.
- Sequence procedure performed for definitive treatment most related to principal diagnosis as principal procedure.

Selection of Principal Procedure III

- A diagnostic procedure was performed for the principal diagnosis and a procedure is performed for definitive treatment of a secondary diagnosis.
- Sequence diagnostic procedure as principal procedure, since the procedure most related to the principal diagnosis take precedence.

Selection of Principal Procedure IV

- No procedures performed that are related to principal diagnosis; procedures performed for definitive treatment and diagnostic procedures were performed for secondary diagnosis.

- Sequence procedure performed for definitive treatment of secondary diagnosis as principal procedure, since there are no procedures (definitive nondefinitive treatment) related to principal diagnosis.

Hospital Utilization Review Coding Education

Texas Administrative Code

- **TITLE 1** ADMINISTRATION
- **PART 15** TEXAS HEALTH AND HUMAN SERVICES COMMISSION
- **CHAPTER 371** MEDICAID AND OTHER HEALTH AND HUMAN SERVICES FRAUD AND ABUSE PROGRAM INTEGRITY
- **SUBCHAPTER C** UTILIZATION REVIEW
- **RULE §371.203** TMRP Review Process

Hospital Utilization Review Coding Education

Texas Administrative Code

- DRG validation confirms that the principal and secondary diagnoses and procedures are sequenced correctly. The principal diagnosis is the diagnosis (condition) established after study to be chiefly responsible for occasioning hospital for care.
- The secondary diagnoses are conditions that affect the patient care in terms of requiring: clinical evaluation, therapeutic treatment, diagnostic procedures, extended length of hospital stay, increased nursing care and/or monitoring, or in the case of a newborn, conditions the physician deems to have clinically significant implications for future health care needs.
- If the principal diagnosis, secondary diagnoses, or procedures are not substantiated in the medical record, are not sequenced correctly, or have been omitted, codes may be deleted, changed, or added.

Newborn Circumcision During Birth Episode

- When a newborn has a routine circumcision done in the hospital during the birth episode, it is not appropriate to assign code Z41.2.

- It is captured with the appropriate ICD-10-PCS procedure code.

Newborn Circumcision After Birth Episode

- If an infant presents after the birth episode, and there is no medical indication for circumcision, but the parents wish to have the baby circumcised, assign code Z41.2, Encounter for routine and ritual circumcision.

- Assign also the appropriate procedure code to show that the circumcision was performed.

Hospital Utilization Review Coding Education

Sources:

- ICD 10 CM/PCS Official Coding Guidelines
- AHA Coding Clinic, Third Quarter, 2018, page 4
- AHA Coding Clinic, First Quarter, 2018, page 16
- AHA Coding Clinic, Fourth Quarter, 2017, page 96
- AHA Coding Clinic, First Quarter, 2017, page 25
- AHA Coding Clinic, Fourth Quarter, 2006, 99

- **Texas Administrative Code**

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