

THE LIVANTA CLAIMS REVIEW ADVISOR



A monthly publication to raise awareness, share findings, and provide guidance about Livanta's Claim Review Services

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Higher-Weighted Diagnosis Related Groups (HWDRG) Validation – Encephalopathy

This month's issue of The Livanta Claims Review Advisor includes case examples in which a newly added diagnosis of encephalopathy was requested by the hospital. The addition of a code for encephalopathy on a resubmitted claim is a prevalent error found in higher-weighted diagnosis related groups (HWDRG) reviews. Livanta shares these case examples to describe common situations in which the diagnosis was added without documentation in the medical record to support the change. By offering these examples, Livanta hopes to provide hospitals with information about documentation guidelines and instructions for the proper coding of encephalopathy.

Documentation of Encephalopathy

The National Institute of Neurological Disorders and Stroke defines encephalopathy as a dysfunction of the brain that has many organic and inorganic causes. Although an altered mental state is the hallmark symptom of encephalopathy, altered mental status is a symptom that can be present *without* encephalopathy. One cannot assume that encephalopathy is present just because an alteration in mental status is noted.

Common Types of Encephalopathy (classified by etiology)

- **Toxic** – usually caused by drugs or other chemicals
- **Metabolic** – caused by systemic illness such as diabetes, renal failure, heart failure, as well as blood and electrolyte abnormalities
- **Septic** – caused by sepsis or systemic inflammatory response syndrome (SIRS)
- **Hepatic** – caused by liver disease and/or failure
- **Hypertensive** – caused by severe untreated hypertension
- **Hypoxic** – caused by a lack of oxygen to the brain
- **Wernicke** – caused by vitamin B1 (thiamin) deficiency, usually as a result of alcoholism
- **Transmissible Spongiform** – caused by prion disease (e.g., mad cow disease)

- **Other encephalopathy** – caused by known conditions such as stroke or urinary tract infection (UTI) without metabolic encephalopathy



Documentation for Clinical Support of Encephalopathy

To clinically support a diagnosis of encephalopathy, the following should be documented in the record:

- One or more physical examinations that indicate the presence of an altered mental status that is not the patient's baseline
- The presence of encephalopathy (documented consistently)
- The type of encephalopathy (documented consistently)
- Clinical support for the type of encephalopathy, such as hypertensive crisis (hypertensive encephalopathy), hyponatremia (metabolic encephalopathy), or poisoning (toxic encephalopathy)
- If a query is necessary, it should be open-ended to avoid the appearance of leading the physician. If hospitals do choose to use the multiple-choice format, it is important to avoid contradictory options. For example, do not offer the option of toxic encephalopathy if there are no clinical indicators for toxic encephalopathy such as poisoning, adverse effect, or chemical exposure.

Queries for Encephalopathy

Supporting a diagnosis of encephalopathy, both clinically and with sufficient documentation, is critical because many of the encephalopathy codes can significantly increase hospital reimbursement.

Encephalopathy is one of the most commonly denied secondary diagnoses during HWDRG audits. These denials are often based on a lack of physician documentation throughout the medical record. The diagnosis is often introduced on a post-discharge query without any explanation as to why it was not previously documented and without clinical information supporting the diagnosis of encephalopathy. In many of these cases, the documentation throughout the medical record indicates that the patient is alert and oriented which is a contradiction to the encephalopathy diagnosis. In some cases, metabolic or toxic encephalopathy is documented on a query but there was no mention of a metabolic or toxic issue that would cause this condition.

When querying physicians for encephalopathy, best practice is to use an open-ended question to allow the physician to provide any answer. This avoids the appearance of leading the physician to a particular answer. For a patient with an altered mental status, ask for the etiology of the altered mental status. Listing multiple types of encephalopathy in multiple-choice query questions with the first several options (and sometimes the only options) given are encephalopathy is inappropriate when this condition was never documented in the medical record. These queries are often found to be leading, and the query answers found to be clinically unsupported.

Query Examples

Three examples of queries are included below. The first two are examples of well-written, non-leading queries for encephalopathy. The third example is a poorly written and leading query.

1. Altered mental status was documented throughout the record and possible encephalopathy was documented on the ED report. Please document the definitive diagnosis related to the altered mental status, and any further detail as to type or etiology.

This query is open-ended and non-leading.

2. Altered mental status was documented several times early in the admission. Once the patient received IV fluids and his hypoglycemia was corrected, he became alert and oriented. Please select the diagnosis causing the altered mental status:

- a) Metabolic encephalopathy
- b) Diabetic hypoglycemia
- c) Brief delirium
- d) Other cause (specify) _____
- e) Unknown cause
- f) Patient determined to be at baseline – altered mental status ruled out.

This query is multiple choice and non-leading.

3. Please document the cause of the altered mental status:

- a) Metabolic encephalopathy
- b) Toxic encephalopathy
- c) Hypertensive encephalopathy
- d) Other encephalopathy
- e) Unknown

This query is poorly written and leading.

Even with the final option of Unknown, it is clear that encephalopathy is the desired answer.

Did you miss the February 2022 *Livanta Claims Review Advisor* related to Physician Queries? Click here to catch up: <https://conta.cc/36AjN5b>

Guidelines for Coding Encephalopathy



The DRG will often change with the addition of encephalopathy as a secondary diagnosis, because in these cases encephalopathy is considered a complication or comorbidity (CC) or a major complication or comorbidity (MCC) which increases the weight (and thus payment) of the DRG.

- When toxic metabolic encephalopathy is due to hepatic encephalopathy, assign G92.8 (other toxic encephalopathy) and K72.90 (hepatic encephalopathy). K92.8 is used for toxic encephalopathy that is not due to drugs or chemicals. *Coding Clinic First Quarter 2022 page 52*
- Encephalopathy due to epilepsy is only coded when specified as chronic or static encephalopathy. Otherwise, encephalopathy is not reported separately when related to a postictal state. *Coding Clinic Second Quarter 2021, page 3*
- When encephalopathy is due to dementia or UTI but the type is not further specified, it is reported using G93.49 (other encephalopathy). *Coding Clinic Second Quarter 2018, pages 22-24*
- Metabolic encephalopathy due to type 2 diabetic hypoglycemia is reported as E11.649 (type 2 DM with hypoglycemia) and G93.41 (metabolic encephalopathy). *Coding Clinic Third Quarter 2016, page 42*

Case Examples of Encephalopathy Not Supported

Livanta reviews many claims that have been re-billed with encephalopathy added as a secondary diagnosis when this condition had not been previously billed. This is often done when a positive response to a post-discharge query cites encephalopathy even though no elements supporting the

occurrence or treatment of this condition are documented in the medical record during the entire hospital stay. These cases are often rejected by Livanta physician reviewers due to a lack of clinical evidence and documentation supporting a diagnosis of encephalopathy. Although encephalopathy can, at times, be validated through a post-discharge query, a physician explanation as to why encephalopathy was not previously mentioned is required.

The following are case examples of DRG changes involving encephalopathy that Livanta has seen in recent reviews:

- **Case Review Summary: Encephalopathy not clinically supported.** The patient was sent to the emergency department (ED) for a period of confusion that had resolved by the time the patient arrived at the hospital. Labs and x-rays were checked, and the patient was diagnosed with an acute exacerbation of diastolic heart failure. From time in the ED through discharge, the patient was alert and oriented to person, place, and time. The hospital queried the physician, who then documented metabolic encephalopathy. The case was sent to a Livanta physician reviewer for clinical validation of metabolic encephalopathy. The physician reviewer determined that it was not clinically valid because the patient was alert and oriented throughout the admission, and also because the physician never documented encephalopathy as a clinical problem and made no attempt to treat or further evaluate this condition.
- **Case Review Summary: Leading query for encephalopathy.** The patient was admitted for acute kidney injury due to dehydration. Altered mental status was documented throughout the record. The patient had a history of dementia and was only oriented to name. Because of the altered mental status, the hospital queried the physician with a multiple-choice question where most of the offered choices were encephalopathy. Upon review, the case was sent to a physician reviewer for clinical validation of metabolic encephalopathy. The query itself was determined to be leading because the first four options introduced the new diagnosis of encephalopathy, making it clear to the physician that encephalopathy was the diagnosis being sought.
- **Case Review Summary: Miscoded type of encephalopathy.** The final diagnosis was documented as encephalopathy due to dehydration. It was coded as metabolic encephalopathy without sufficient supporting documentation. The coder may not assume metabolic as the type, as there is no listing in the coding index for encephalopathy due to dehydration. Therefore, the reported code was revised from G93.41 (metabolic encephalopathy) to G93.49 (encephalopathy of other specified type), changing the MCC to a CC.

Conclusion

Based on HWDRG claim reviews conducted by Livanta, many hospitals could benefit from focused training on the proper documentation and coding of encephalopathy, as well as the query requirements regarding code changes related to this diagnosis. Accurate coding supported by thorough documentation in the medical record ensures proper claim submission and payment.

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 diagnosis related group (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?

Should you have questions, please email ClaimReview@Livanta.com.

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