Correctly Documenting Encephalopathy

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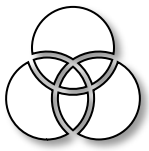
There are a wide range of psychiatric and neurological mental status and brain disorder diagnoses that are not clearly clinically delineated or defined. These diagnoses often coexist and frequently require legitimate medical care, treatment, and assessment. Length of stay for inpatient care is often increased either by waiting for resolution of symptoms or by finding placement. Documentation of the clinical indicators supporting the diagnoses and documentation of the diagnoses themselves is often sparse. Coding mental status diagnoses and compliant querying for accurate documentation of these diagnoses is fraught with difficulties. Denials of payment are common, making reimbursement for care provided difficult to attain.

How can we create some order out of the confusion?

Whenever coding, querying, denying or appealing mental status diagnoses, ask yourself these questions.

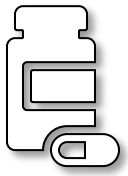


1. Does the documentation refer to *symptoms* of diagnoses or actual medical *diagnoses* or both?
   - Is there documentation of the patient's baseline mental status against which to compare?
   - If both, are the symptoms integral to the diagnoses also documented?
   - If both, which of the symptoms or diagnoses exclude each other within ICD-10?
   - Is the symptom and/or diagnosis a medical or psychiatric diagnosis?
   - If it is a diagnosis, are they acute or chronic conditions?
   - If it is an unspecified diagnosis, can the documentation be compliantly specified?

(If the documentation does not answer these questions, a query may be indicated.)

2. What clinical indicators of mental status conditions can be found?
   - Comparisons to "baseline" mental status and improvement with treatment
   - Lethargy, severe fatigue, muscle twitching weakness or shaking, ataxia
   - Need for sitter and or constant presence of caregiver or order for restraints
   - EEG results and Radiology results may or may not be supporting
   - Laboratory test results (ex. electrolyte, medication levels, drug and alcohol levels)
   - Mental Status exams documenting altered cognition, impaired judgment, or memory.
   - Consultation with neurology +/or psychiatry
   - History of sports or trauma injuries

(Look for these symptoms throughout the record including in EMS, ED/triage and nursing, nutrition and therapy documentation)



3. What associated treatments or monitoring can be found in the documentation?
   - Treatment of underlying condition (i.e. antibiotics, lactulose, insulin, dialysis, chelation, fluids, oxygen, psychiatric medication, etc.)
   - Supportive care to prevent injury while mental status is disrupted
   - Regular mental status +/or neuro checks
   - In chronic diagnoses, prevent of progression of diagnoses

When Encephalopathy is the principal diagnosis or is sequenced secondary but is unspecified, you are at high risk for claim denial. When psychiatric diagnoses and/or types of Dementia are documented concurrently with mental status diagnoses you are at equally high risk for claim denial. These are times when compliant queries for accurate improved documentation are essential.

The following page is a summary *some* of the most common mental status codes. Note that there are cc and mcc opportunities among both symptom and diagnosis codes.

Diagnoses	Summary Definitions	Code	MCC/CC Status
Acute Encephalopathy (Encephalopathy, Unspec.)	Disorder or disease of brain; "global cerebral dysfunction" **Reversible**, temporary (Delirium and AMS are symptoms.)	G93.40	**CC**
Toxic (May include Toxic Encephalitis)	**Due to** medications or toxins	G92	**MCC**
	If "adverse drug rxn ***also*** use	T36.8X5A	
	If poisoning**, also** use **(May code 1st toxic agent)**	T43.592A T51-T65	
Metabolic	**Due to** water, electrolyres, vitamins other internal chemicals (incl. due to **Sepsis/Hypoglycemia**)	G93.41	**MCC**
Hepatic	**Due to** Liver's inability to remove toxins **–** Codes to Liver Failure		
	with "coma"	K72.91	**MCC**
	without coma	K72.90	
Hypertensive	**Due to** (must say) "extreme bp"	I67.4	**CC**
CVA related ("Other Encephalopathy")	**Due to** (must say)	G93.49	**CC**
	CVA		
Neonatal	**Due to** Hypoxic Encephalopathy **-HIE**		
	mild to moderate	P91.60-P91.62	**CC**
	severe	P91.63	**MCC**
(Post-ictal is integral to seizure code and ***not sepately coded***)			
Chronic Encephalopathy	Disorder of brain, "slow and progressive+/or **irreversible, "static"**		
Anoxic	Brain damage due to lack O2	G93.1	**CC**
CTE	Post-concussional syndrome	F07.81	
Korsakoff (alcohol related)	Related to Thiamine deficiency	G31.2	
Wernicke's	**Must be specifically dx** (Due to nutritional deficits)	E51.2	**CC**

About the Author

Maggie brings more than twenty years of clinical and legal experience to the MRI Clinical Documentation Improvement Department. Early in her career, after having received her JD from Villanova shortly after her BSN from the University of Pennsylvania, Maggie became one of the forerunners of what would formally become CDI as she drew on her legal and clinical experience to reduce denials and improve CMI at multiple facilities and systems. Today, Maggie specializes in implementing contemporary and comprehensive CDI consulting for facilities and practices ranging in size from 2000+ bed systems to private practices.

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Note

Some types of Dementia (i.e. Alzheimer's, Lupus, HIV, Parkinson's etc.) may also be assigned a cc, especially if associated with behavioral problems. Also, sometimes Encephalopathy is *not* present but symptom codes accurately describing the confused state of the patient are also assigned MCC/CC.(i.e. some psychiatric states, auditory hallucinations, Glasgow Coma Scores, "Coma" without GCS, etc..)

References

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