

# Background Information: V56.0 as Principal Diagnosis for Inpatient Admissions for Renal Failure Patients

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## I. Issues Associated with use of V56.0 as Principal

- **Loss of revenue.** Hospitals on balance are probably losing revenue by using V56.0 as a principal diagnosis in certain renal failure accounts.
- **Lower CMI.** On balance, use of V56.0 is probably also reducing the hospital's case mix index and negatively impacting severity outcomes data.
- **Inconsistent official advice.** *Coding Clinic* has inconsistent and out-of-date advice.
- **Difficulty getting paid.** There have been issues with Medicaid in the past. See item IV below.
- **Target for audits.** Because of the inconsistent and out-of-date advice, outside reviewers can point to differing citations to support their changes. Revenue enhancement companies can argue changes to increase the DRG; government audit agencies can argue changes to decrease the DRG. The coder can't win. This makes renal failure charts attractive targets for auditing.
- **Inconsistency of the Colorado database.** To the extent that hospitals in Colorado are using V56.0 inconsistently, the accuracy and integrity of CHA's Colorado database are affected.

## II. *Coding Clinic* References, in chronological order, with Editorial Comments:

1984, September-October, page 3:

"Renal dialysis. Patients with end-stage renal disease are usually admitted for renal dialysis in order to manage symptoms arising from renal failure. In this instance, we advise that the patients' principal diagnosis be admission for extracorporeal dialysis, V56.0. The underlying disease condition(s) can then be recorded secondarily, following normal coding rules for the conditions that apply..."

Editorial Comments: This advice is 27 years old, and was written only a year after the initiation of the DRG system in October of 1983. At that time, inpatient hospital admissions still carried a long length of stay and the shift of many services to the outpatient setting had only just begun. It is quite likely that patients were indeed being admitted to inpatient status at that time solely for routine dialysis. The DRG system was designed, in part, to force a shortening of length of stay and remove less acute cases out of the inpatient setting. Today, 27 years later, dialysis is typically and routinely performed at dialysis centers on an outpatient basis, and it would probably be rare today that a patient would be admitted to inpatient status for the sole purpose of performing routine dialysis. Today, a patient would likely be admitted to inpatient status only for a decompensation of the renal failure, which could be due to noncompliance, to a progression of the disease process, to the effects of concurrent disease processes or other causes. Typically, the patient is admitted with volume overload, hyperkalemia, triggering of congestive heart failure, or a combination of these and other conditions.

It is possible that the writers in 1984 actually meant that V56.0 should be used only for admissions for routine dialysis, but that is not what was actually written in the *Coding Clinic*. "Managing symptoms" of renal failure most certainly includes managing hyperkalemia and fluid overload, which are the two most common symptoms for an inpatient admission today of a patient who is in decompensated renal failure.

Even though this advice is old and outdated and in need of modernizing to match contemporary practice, it has never been officially superseded by subsequent advice. *Coding Clinic* typically includes a statement with new

advice that the new advice is either consistent with or supersedes previous advice, but that has not been done for this renal failure issue. Subsequent advice has been given, however, which is *inconsistent* with this 1984 advice. Therefore, the advice theoretically remains equally binding, even though *Coding Clinic* has been inconsistent, and this has permitted auditors and reviewers to cite this advice to support recommended changes when hospitals have coded some code other than V56.0 as principal.

### **1993, Fourth Quarter, page 34**

"Q: A patient was admitted to hospital A with acute renal failure. After study, it was determined that the patient would require hemodialysis. Hospital A does not provide hemodialysis. Therefore, when stabilized, the patient was transferred to hospital B and admitted for renal dialysis. What is the principal diagnosis for hospital A? What is the principal diagnosis for hospital B? A: The principal diagnosis for hospital A is acute renal failure. Code 584.9, acute renal failure, unspecified, should be assigned. The principal diagnosis for hospital B is admission for renal dialysis. Code V56.0 extracorporeal dialysis should be assigned. In addition, code 584.9, acute renal failure, should be assigned as the secondary diagnosis."

Editorial Comments: This scenario is unlikely, although it could happen. Acute renal failure is most often due to pre-renal causes (dehydration, hypotension) and is usually resolved with IV fluids. When ARF requires acute dialysis, the ARF is usually unusually severe due to trauma, sudden ischemia, toxicity, sepsis or similar serious conditions and can only be managed with urgent dialysis. Such a patient is unlikely to have an isolated ARF and would most likely require treatment for multiple co-morbidities, even at "hospital B." A patient with this type of ARF requiring urgent dialysis is by definition not stable, so the *Coding Clinic* entry reading "when stabilized" does not make a lot of sense.

Even though the scenario is flawed, this advice supports the idea that a patient in a state of acute decompensation should nonetheless carry a principal diagnosis of V56.0 for an inpatient admission.

### **2001, Second Quarter, pages 12-13**

"Q: When a patient is admitted to the hospital with a diagnosis of hyperkalemia due to noncompliance with dialysis and the treatment consists of dialysis, what should the principal diagnosis be: hyperkalemia or chronic renal failure? A: Assign code 276.7, hyperpotassemia as the principal diagnosis. Assign code 585, chronic renal failure, code V45.1, renal dialysis status, and code V15.81, noncompliance with medical treatment, as secondary diagnoses. Code 39.95, hemodialysis, should be assigned for the hemodialysis. In this case, the patient was admitted specifically for treatment of the hyperkalemia, not the chronic renal failure. As previously stated in *Coding Clinic*, Second Quarter, 1990, 'The circumstances of inpatient admission always govern the selection of principal diagnosis. The principal diagnosis is the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.'"

Editorial Comments: This scenario seems to be inconsistent with the 1984 and 1993 advice. There is no question that the hyperkalemia is "a symptom arising from the patient's renal failure." The 1984 and 1993 advice suggests that V56.0 is appropriate; this 2001 advice does not even address the issue of V56.0, and only debates between the hyperkalemia and chronic renal failure codes as possible principal diagnoses. There is no mention in this entry of the advice being consistent with or superseding previous advice. The writer of the entry does not seem to be conscious that the advice seems to be a reversal of previous advice.

Furthermore, the statement that the patient was admitted "not for the chronic renal failure" is absurd, since that is precisely what the patient is being admitted for. This is not the same scenario as a patient with, say, a neoplasm who is admitted for anemia and treated with blood transfusions. In the neoplasm scenario, the treatment is not directed at the neoplasm (i.e., chemotherapy or surgical resection); treatment is directed at the anemia (i.e., blood transfusion), thus supporting coding the anemia as principal, even though it is a secondary effect of the neoplasm. In the case of chronic renal failure, hyperkalemia is inherent to the CKD and the treatment of dialysis is most definitely directed at treating the patient's kidney failure, which then resolves the resulting hyperkalemia. Other than this question in 2001, it appears that no one has ever attempted to make the case that really it would make more sense to code the renal failure as the principal diagnosis rather than the manifestations of the renal failure, such as the fluid overload or hyperkalemia.

## 2001, Second Quarter, page 13

"Q: What if this same patient is admitted with fluid overload and congestive heart failure due to noncompliance with dialysis and again, treatment consists of dialysis? A: When the patient is admitted in congestive heart failure resulting from fluid overload, secondary to noncompliance with dialysis treatments, assign code 428.0, congestive heart failure, as the principal diagnosis. Code 585, chronic renal failure, code V15.81, noncompliance with medical treatment, and code V45.1, renal dialysis status, may be assigned as additional diagnoses. Code 39.95, hemodialysis, should be assigned for the dialysis treatment. Fluid overload is a component of congestive heart failure and should not be coded separately. This advice is consistent with that published in *Coding Clinic*, Third Quarter, 1996, page 9."

Editorial Comments: It appears that the writer in this scenario is attempting to illustrate that while it would be logical (at least in this writer's mind) to code the fluid overload as principal consistent with the previous scenario (where it was advised to code the hyperkalemia as principal), the coder cannot do so because fluid overload may not be separately coded when 428.0 is already coded.

This entry is unfortunately shallow and incomplete and has been misinterpreted by coders as a mandate to code CHF over renal failure and RF manifestation codes anytime the two co-exist. It is quite possible for a patient to be in decompensated chronic renal failure, but not have a decompensated CHF. If such a patient has a chronic history of CHF and comes in because of decompensated renal failure with hyperkalemia, for example, then it may be (depending on the specific documentation of the case) that the hyperkalemia should be principal and not the CHF.

For our purposes of discussing V56.0, this advice still seems to be inconsistent with the advice from 1984 and 1993. There is no mention of the pros or cons of using V56.0 or any attempt to distinguish this scenario from the 1984 and 1993 scenarios.

## 2004, First Quarter, page 23

"Q: *Coding Clinic* Second Quarter 2001, pp. 12-13, provided code V45.1, renal dialysis status, as an additional diagnosis for a patient with chronic renal failure on maintenance dialysis, who was admitted to the hospital for treatment of hyperkalemia. Should code V56.0, encounter for dialysis and dialysis catheter care, extracorporeal dialysis, be listed instead of code V45.1? A: No, code V56.0 may not replace code V45.1. When the patient is being maintained on dialysis, code V45.1, renal dialysis status, should be assigned as an additional diagnosis. When a patient is seen **solely** for dialysis treatment, code V56.0, encounter for dialysis and dialysis catheter care, extracorporeal dialysis, is first listed as the reason for the encounter and code V45.1 is assigned as a secondary diagnosis if the patient is being maintained on dialysis. A code for the renal condition is also assigned as an additional diagnosis..."

Editorial Comments: Most of this scenario is not relevant for our purpose of discussing V56.0, except for the sentence, "When a patient is seen **solely** for dialysis treatment, code V56.0...is first listed as the reason for the encounter..." Notice that the word "solely" was bolded in the *Coding Clinic*. This entry seems to directly contradict the 1984 and 1993 advice, which states that patients are being admitted "in order to manage symptoms arising from renal failure."

### III. Impact on MS-DRG of Principal Diagnoses

A typical set of codes would include 585.x (for the chronic renal failure), 403.9x (for the hypertension that most often accompanies the renal failure), 276.7 (hyperkalemia), and 276.69 (fluid overload). Using all these possibilities as principal diagnoses, plus V56.0, yields the following table. The third column for relative weight shows the relative weight when V56.0 is principal at 0.8944. All relative weights that are less than that are left-justified and non-bolded; all relative weights that are more than that are right-justified and bolded. This highlights the impact on reimbursement and case mix index of changes in the principal diagnosis.

Probably most CKD patients who come in with decompensated renal failure as evidenced by hyperkalemia and/or fluid overload requiring dialysis also have a variety of co-morbidities.

- **MCCs.** Common accompanying diagnoses that are MCCs include a number of pneumonias, acute diastolic and/or systolic heart failure, and ESRD.
- **CCs.** Common accompanying diagnoses that are CCs include 403.91, chronic diastolic and/or systolic heart failure, and ARF/AKI.

When V56.0 is principal, the MS-DRG is not affected by CCs/MCCs and will always be MS-DRG 685. When V56.0 is not principal, then the results are mixed and would depend greatly on the acuity of the patients. Low acuity patients with a principal of hyperkalemia, for example, could end up with a lower-weighted DRG, but higher-acuity patients with a principal of hyperkalemia would end up with a higher-weighted DRG.

Also of interest is what happens when we consider using the renal failure (or 403.9x) as the principal diagnosis. For high acuity patients, this yields the highest relative weight of all, a relative weight of 1.6407, which is a significant increase over 0.8944. Right now, *Coding Clinic* does not permit the use of a renal failure code as a principal diagnosis, but it actually would make more sense in a lot of cases.

Principal diagnosis	MS-DRG	Relative weight	ALOS/GLOS
V56.0	685	0.8944	3.40/2.50
276.7 (hyperkalemia)	641 (without MCC)	0.6916	3.60/2.90
	640 (with MCC)	<b>1.1400</b>	5.10/3.60
276.69 (fluid overload)	641 (without MCC)	0.6916	3.60/2.90
	640 (with MCC)	<b>1.1400</b>	5.10/3.60
585.9 (CKD)	684 (without CC/MCC)	0.6587	3.40/2.80
	683 (with CC)	<b>1.0243</b>	4.90/4.00
	682 (with MCC)	<b>1.6407</b>	6.80/5.10
403.90 (HTN/CKD)	684 (without CC/MCC)	0.6587	3.40/2.80
	683 (with CC)	<b>1.0243</b>	4.90/4.00
	682 (with MCC)	<b>1.6407</b>	6.80/5.10
585.6 (ESRD)	684 (without CC/MCC)	0.6587	3.40/2.80
	683 (with CC)	<b>1.0243</b>	4.90/4.00
	682 (with MCC)	<b>1.6407</b>	6.80/5.10
403.91 (HTN/ESRD)	684 (without CC/MCC)	0.6587	3.40/2.80
	683 (with CC)	<b>1.0243</b>	4.90/4.00
	682 (with MCC)	<b>1.6407</b>	6.80/5.10

#### IV. Difficulty being paid by Medicaid

At least two hospitals have reported in the past problems with Medicaid denials. Medicaid has denied accounts with V56.0 as principal, and also denied accounts with something other than V56.0 as principal. This had especially been a problem with patients in the country illegally who could not go to outpatient dialysis and were forced to go to inpatient hospitals for dialysis when their renal failure was out of control.

Is this still happening? Does it happen with payers other than Medicaid?

There are actually two separate but related problems here. One problem is so-called "correct" coding, which is difficult to determine given conflicting official advice. The second problem is whether any particular payer in any particular set of circumstances will pay the account. Payers are not supposed to require hospitals to submit incorrect codes in order to be paid, although we all know that happens.

## V. Courses of Action for the HIM/CHA Advisory Group

We very likely have inconsistency between hospitals on how we code these records. We can research the issues by

- sharing what we are doing at our hospitals on this issue, to include bringing in any written policies and procedures, any external or internal audit changes that have been imposed together with their rationales for the changes, any payment denials together with the basis for the denials, and anecdotal comments from coders and managers.
- doing a run off the CHA database to investigate the use of V56.0 for inpatient accounts. This could yield volumes, evidence of clustering at some hospitals and not others, and other variables that we could build into a database query.
- after reviewing all the collated evidence, discussing the *Coding Clinic* discrepancies and consider how we would resolve them, if it were up to us. After determining the way we think the rules *should* be written, consider writing *Coding Clinic* with a description of our proposed solutions and an appeal to consider adopting them. Consider, among other things, permitting coding renal failure (or 403.9x) as principal.