DOCUMENTING ALTERED MENTAL STATUS

By Deborah Hale

When a patient is admitted with an acute change in mental status, the physician should drill down to determine the known or suspected cause(s) of the change. With this condition, there is a danger of diagnoses being reported incompletely, which may lead to payment denial, and/or outcomes data that don’t reflect the true cost, length of stay and expected mortality rates of the patient.

Consider the following case study:

Ms. Jones is a 79-year-old woman brought to the emergency department by her daughter, who reports the patient has been sleeping more than usual and has been unusually difficult to arouse today. Vital signs are blood pressure of 99/60 mm Hg, pulse of 110 beats/min, respiratory rate of 24 breaths/min and temperature of 99° F. Labs show white blood count (WBC) of 12,500 cells/mm³ with left shift and 10% bands. Her urine is positive for WBCs too numerous to count, bacteria and nitrites. Blood glucose is 180 mg/dL; the patient is not diabetic. After study, the patient is determined to have a urinary tract infection due to *Escherichia coli*.

The physician reports the diagnosis as “altered mental status due to urosepsis.” The resulting diagnosis-related group (DRG) assignment presumes a patient with a low severity of illness, which is not accurate for this patient. The payment of $4,239 (based on a hospital-specific rate of $5,500) and expected length of stay of 3.5 days probably won’t cover the cost of care for Ms. Jones, or for other patients like her.

To more accurately report the severity of illness, the physician should consider the significance of the altered mental status, laboratory values and vital sign abnormalities that were present on admission. Were these findings due to a localized urinary tract infection? Could the altered mental status, abnormal vital signs and laboratory values represent the body’s systemic inflammatory response (SIRS) to the urinary tract infection? Is the mental status change due to toxic encephalopathy secondary to sepsis?

Physicians should consider any alternate diagnoses that may reflect the reason for the altered mental status. If, for example, the status is due to toxic encephalopathy, it should be documented and coded in lieu of “altered mental status” (see table). Documenting more specific terminology changes the DRG assignment to better reflect the severity of illness, associated cost and length of stay. In the table below, note the payment difference between more complete documentation of the case (Alternate DRGs) and less complete documentation (Original DRGs).

Encephalopathy is a blanket term for generalized cerebral dysfunction; its hallmark is an altered mental state. When reporting a diagnosis of encephalopathy, physicians should specify the type (metabolic, hypertensive, toxic) and report the underlying known or suspected disease process, such as:

- liver disease
- alcoholism
- metabolic disorders
- blood pressure over 250/150 mm Hg in patients with chronic hypertension
- brain tumor or trauma
- toxic effect of drugs

Complications-comorbidities related to altered mental status include:

- alcoholic encephalopathy (includes alcoholic dementia, excludes Wernicke-Korsakoff)
- drug-induced delirium
- hypertensive encephalopathy
- transient encephalopathy due to dialysis
- dementia with delirium or delusion or depressed mood (specify type of dementia, such as arteriosclerotic, vascular, senile, pre-senile)
- Alzheimer’s dementia with behavioral disturbance

Major complications-comorbidities related to altered mental status include:

- encephalopathy—not otherwise specified
- encephalopathy—hepatic, metabolic, toxic
- cerebral edema.

Deborah Hale, a certified coding specialist, is president of Administrative Consultant Service, LLC, in Shawnee, Okla. E-mail your coding questions to acphospitalist@acponline.org.

<table>
<thead>
<tr>
<th>Original DRGs reported</th>
<th>Alternate DRGs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Urinary tract infection (unspecified), or urosepsis</td>
<td>1. Severe sepsis due to UTI</td>
</tr>
<tr>
<td>2. Altered mental status</td>
<td>2. Systemic inflammatory response syndrome</td>
</tr>
<tr>
<td>MS-DRG 690 $4,239* Average LOS 3.5 days</td>
<td>3. Toxic encephalopathy (major complication)</td>
</tr>
<tr>
<td>MS-DRG 871 $10,140* Average LOS 5.4 days</td>
<td></td>
</tr>
</tbody>
</table>

*Payment based on hospital-specific rate of $5,500.

LOS= length of stay; MS-DRG= Medicare Severity Diagnosis-Related Group; UTI= urinary tract infection.