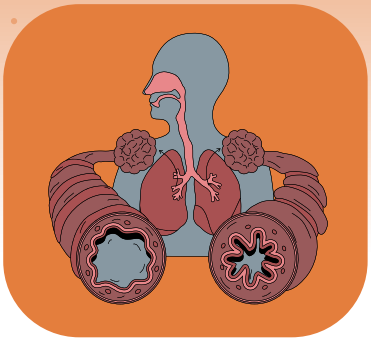
NORWOOD

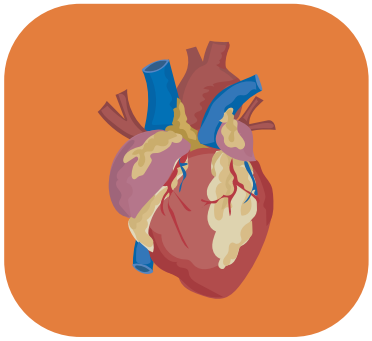
Coding in the Gray

Why Human Judgement Still Matters



Pneumonia

Encephalopathy



Chronic & Stable

Functional Quadriplegia

Morbid Obesity & GLP-1s

5 Complex Coding Scenarios

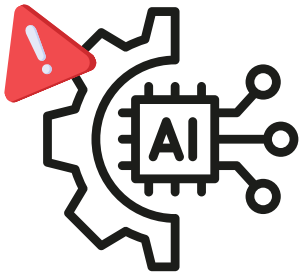
Part 1 of 2

The Myth of Automation
Introduction

There is a LOT of talk these days about automation.

Autonomous coding solutions that can code with near-perfect accuracy–and no human intervention

Providers picking a code from a drop-down menu, enabled by a computer-generated prompt, and voila: Maximized billing and denial-proof revenue.



WE'RE NOT BUYING IT.

We've been hearing talk of autonomous coding since at least 2007-08, and it never seems to happen the way the predictions say.

Denials persist. Errors continue. And more myths are perpetuated.

What makes full coding automation a fiction, even in the age of AI?

Coding Rules are Constantly Changing

Every time you think you have this arcane art mastered, a new Coding Clinic comes out, the Official Guidelines for Coding and Reporting are updated, or entirely new ICD-10-CM, PCS, and CPT codes are released.

Many technologies up to and including the latest LLMs are trained only on existing data–if they'trained on coding rules at all.

Coding is Subjective

Coding operates in the gray–just like clinical medicine. Think about what it takes to establish an organizational definition of encephalopathy or functional quadriplegia among multiple stakeholders.

Even outpatient coding requires judgement: What constitutes sufficient MEAT criteria for reporting dementia or chronic respiratory failure, for example

In short, Medical Coding is HARD

As a result

We believe Coding still falls in the purview of humans

At minimum, humans should be serving in an auditing capacity, with ultimate approval of code assignment

This special report—part 1 of a 2-part series—details some thought-provoking coding scenarios.

Please share liberally; we hope these spark conversations in your own organization.

As always, we love to receive feedback on these reports.
What are your toughest coding challenges?

Do you think automation is possible?

Contact us at info@norwood.com

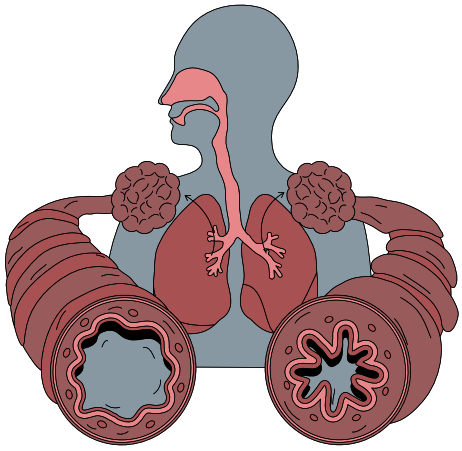
Pneumonia
Scenario 1

Pneumonias are diagnosed through:

1) signs and symptoms—elevated temperature/fever or hypothermia, chills, fever, confusion, cough, sputum production,

2) typically an acute pulmonary infiltrate seen on a chest X-ray or CT scan.

It might sound simple, easily outsourced to a machine.. but there is much more subtlety than that.



Normal Bronchiole | Inflamed Bronchiole

Scans don't always pick up pneumonia,

particularly if the patient is dehydrated or has severe leukopenia. Or, the pulmonary infiltrate might be present but obscured by interstitial lung disease, which shows up as white and obscures the pneumonia imaging.

A repeat x-ray can pick up the pneumonia... but these aren't always performed if the patient is improving.

So long story short, pneumonia can be missed by a physician.

And needs to be clarified by a CDI or coding professional, who can with a query get the physician to document suspected pneumonia. Recall possible/suspected/likely diagnoses can be coded in the inpatient setting.

DRG 195 (Simple pneumonia and pleurisy without CC/MCC) has a relative weight of 0.6285 and a geometric mean length of stay of 2.2days. If the CDI review results in the addition of a major complication/comorbidity, it groups to DRG 193

(Simple pneumonia and pleurisy with MCC) with a relative weight of 1.3144, with a geometric mean length of stay of 3.9 days.

That's financial and quality impact. The patient gets to stay longer and be treated accordingly.

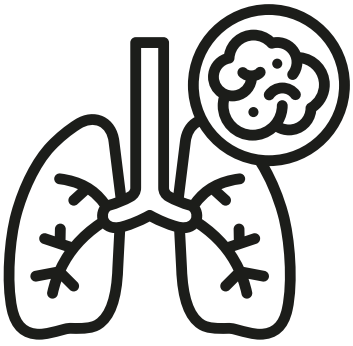
Community-acquired Pneumonia (CAP)

presents its own set of obstacles. An authoritative paper published by the American Thoracic Society in 2019 (link below) ended the use of the term "healthcare acquired pneumonia/HCAP" and revised the guidelines to include staphylococcus, pseudomonas, and other aerobic gram-negative bacteria CAP based on the presence of certain risk factors.

As in the above instance, a CDI or coding professional could step in to query for additional specificity, moving a simple community acquired pneumonia to a gram-negative pneumonia when clinical indicators warrant.

A good place to look for evidence of the pneumonia type is

the antibiotic order

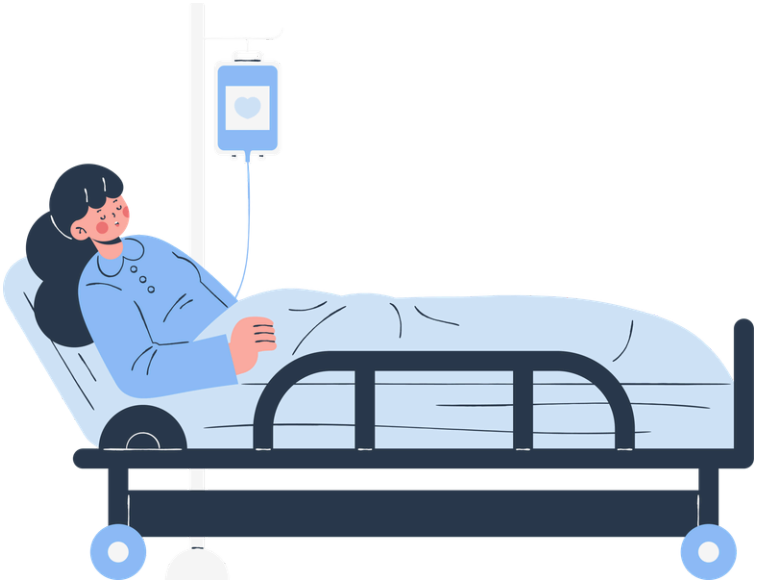


Complex pneumonias with an MCC group to DRG 177 (Respiratory infections and inflammations with MCC), which has a relative weight of 1.5627 and a geometric mean length of stay of 4.4 days.

Chronic Obstructive Pulmonary Disease (COPD)

is a common comorbid condition in these patients, per the paper referenced below ("gram-negative bacilli are more common causes of CAP in patients with comorbidities, such as COPD").

Functional Quadriplegia
Scenario 2



Functional Quadriplegia (ICD-10-CM code R53.2)
is historically a difficult coding scenario, for a few reasons:

1) Historically it isn't term physicians document, even though it's a common condition among certain populations. Physicians and other caregivers are more apt to use "bedbound, total care" or other like terms.

2) It's got payment ramifications. R53.2 is a major complication/comorbidity (MCC). It also has impact in risk adjustment, grouping to CMS-HCC 70 in Version 24 and 180 in V28.

3) Because of 1 and 2, payers deny it–especially if it is the only MCC reported on a claim.

But times have changed. Coding software has improved and the term has perhaps become more commonplace through use and education.

Seems simple...

but is it?

We posed a 2025 LinkedIn poll to gauge where folks are with compliant capture of this condition. Here are the results:

As you can see, significant variation exists, with the largest bucket of respondents (46%) selecting "fair, reporting takes work."

Only 19% said they had no reporting problems with this diagnosis.

If you answered fair or poor to the poll, we've gathered some helpful resources to help you get on track.

1 **Functional quadriplegia is defined as complete immobility resulting from severe physical disability or frailty, without physical injury or damage to the brain or spinal cord.**

It's important to note that this condition is distinct from neurological quadriplegia, which is due to spinal cord injury and is coded differently. The Pinson and Tang article cited in the references delineates this well.

The ACDIS Pocket Guide offers the following tips for consideration: 2

"Functional quadriplegia should be considered with patients diagnosed with severe, end-stage dementia or an advanced progressive neurodegenerative disorder such as multiple sclerosis, amyotrophic lateral

sclerosis (ALS), cerebral palsy, or Huntington's disease. The nursing admission functional assessment should provide clinical validation demonstrating the patient's inability to move extremities, requiring total assist with activities of daily living. These patients often present with contractures and muscular atrophy."

A long-term nursing home patient admitted to an acute care hospital for treatment would be a candidate.

3

R53.2 has the following Excludes1 notes, Frailty NOS (R54); hysterical paralysis (F44.4); immobility syndrome (M62.3); neurologic quadriplegia (G82.5-); quadriplegia (G82.50). As a reminder an "Excludes1" note in ICD-10-CM means that these conditions cannot occur together and should not both be reported.

It's rare to have R53.2 as a principal diagnosis, so CDI professionals should review the record for the underlying disease process and be prepared to query the provider if absent.

ACDIS notes that the reason for an acute care admission for these patients is often a complication resulting from the immobility.

The 2026 ACDIS Pocket Guide states that for patients with diagnosis of severe, end-stage dementia or an advanced progressive neurological disorder, it is clinically valid to add this dx to the medical record.

Functional quadriplegia should not be expected to improve with time or treatment, but it should be captured because the resources expended on these patients are considerable.

Other conditions that may be present with R53.2 include pressure ulcers and malnutrition.

AHA Coding Clinic, Fourth Quarter 2008, p. 143, contains additional information for compliant reporting. We recommend reviewing that entry with your coding and clinical teams.

Chronic & Stable
Scenario 3

What's your take on "chronic and stable" as a basis for code assignment for risk adjustment? No official guidance says whether this terminology is sufficient for coding.

But it's time might have come and gone.

We hosted Betty Stump on the Off the Record podcast and enjoyed the interview very much. Betty isn't afraid to give her opinion on the documentation gray areas experienced coders know. The ones that, as she said on the show, can elicit "five opinions from three coders in the same room."

Chronic and stable definitely qualifies. It's often used by providers as the only supporting documentation to describe a diagnosis.

Historically, Stump has seen coders, auditors, CDI specialists that were willing to take a notation of "stable, continue plan of care," for code assignment. But times are changing.

"I think we are seeing a shift where we are recognizing that's not sufficient. Simply seeing a notation of 'stable' doesn't really tell me that the clinician fully assessed it," she says.

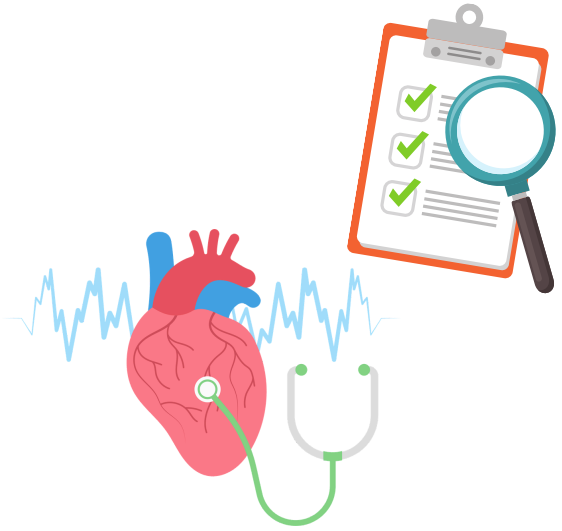
Stump would prefer to see further corroborating evidence throughout the body of the clinical record. Lacking anything else in the history and exam, a sudden appearance of "chronic and stable" will raise questions from an auditor.

Teach your physicians to think in ink:

How do you know the diagnosis is stable?

Where is the evidence you evaluated it?

What is the plan of care?



Physicians working with a patient under the management of a specialist—a family practice provider deferring to a cardiologist, for example—often default to this terminology. For example, "patient's atrial fibrillation chronic and stable."

There are better options, Stump says. "I want to see documentation that says, 'patient currently compliant with medication as prescribed by cardiology. Next cardiology appointment next month.'"

Morbid Obesity
Scenario 4

At the 2026 ACDIS conference we heard an interesting obesity coding question posed during a Q&A session at the Outpatient Symposium:

Should we continue coding morbid obesity if a patient was previously morbidly obese, but their BMI is now below 35 due to active use of GLP-1 medication?

With the reasoning that, without the drug, their obesity will return?

And therefore is an active disease being treated (MEAT criteria met)?

The person raised an interesting, analogous(ish) example of a patient with hypertension and on ACE inhibitors. You still code hypertension in that scenario.

If a patient has a diagnosis of hypertension and is being treated with medication, the condition is considered chronic and ongoing, even if it's currently well-controlled.

- **"Controlled" ≠ "resolved"**
- **The patient is still under treatment (antihypertensive meds)**
- **It remains a reportable condition that affects care and risk adjustment**

If Glucagon-like Peptide-1 (GLP-1) isn't on your radar yet, they should be.

These increasingly popular obesity and diabetes treatments are helping patients lose significant amounts of weight

–but they're also introducing new challenges for documentation, coding, and risk adjustment.

BUT, regarding obesity, the answer to the symposium question seems to be no. According to the official coding guidelines morbid obesity diagnosis + BMI must be present. BMI under 35 does not rise to morbid obesity reportability.

AND, the obesity is NOT guaranteed to return. **Though it may. And here, we get complexity.**

Major health organizations like the AMA and WHO classify obesity as a chronic, relapsing, multi-factorial, neurobehavioral disease. A Lancet article defines it as clinical obesity as "a systemic, chronic illness directly and specifically caused by excess adiposity."

Without the GLP-1, would the obesity come back?

It sparked some thoughtful commentary and debate. GLP-1s are a new wonder drug for the treatment of obesity, and with CMS starting up the Medicare GLP-1 Bridge program July 1 we're going to see a lot more of them prescribed.

Have you had this debate in your organization? What do you think? There does not seem to be a Coding Clinic out there on this issue.

Note: This was in the context of risk adjustment/HCC reporting.

Encephalopathy
Scenario 5

The third most denied diagnosis—and rapidly climbing on that list, per the ACDIS 2026 CDI Industry Overview Survey—is encephalopathy.

It's tricky to code, mainly because providers use synonymous terms like "acute confusion" or altered mental states rather than naming the condition, or employ subjective terms like "appears altered" or "seems consistent with" --which gives an auditor plenty of ammunition to issue a denial.

On an episode of Off the Record podcast, Tarman Aziz, MD, pointed to weak physician nomenclature and other underlying disease processes as the chief reasons coders struggle with encephalopathy. The result? They will often code it when it's not warranted.

"Context matters first and foremost for the so-called encephalopathy that you may be seeking to clinically validate," Aziz says.

"Easy and illustrative examples of that would be the demented patient who's having a behavioral disturbance because you pulled them into the hospital to get their heart, kidney, liver, or whatever solid organ is now failing them."

Alzheimer's patients decompensate when you remove them from their routine. But coders don't always pick up on that nuance.

The result is overcoding--encephalopathy instead of the more appropriate dementia with behavioral disturbance.

Can an AI without additional context of that patient pick up on these context clues? Possible.

Worth staking your organization's financial future on it? Doubtful.

References & Resources

- ACDIS, 2026 Pocket Guide
- ACDIS, 2025 CDI Week Industry Survey: https://acdis.org/cdi-week/2025-cdi-week-industry-survey
- American Journal of Respiratory and Critical Care Medicine, "Diagnosis and Treatment of Adults with Community-acquired Pneumonia": https://pubmed.ncbi.nlm.nih.gov/31573350/
- Off the Record podcast, From Encephalopathy to Edema: Talking chart review with Dr. Tarman Aziz: https://podcasts.apple.com/ph/podcast/from-encephalopathy-to-edema-talking-chart-review-with/id1641739619?i=1000747019048
- Off the Record podcast, Risk Adjustment Reality Check: What's Working—and What Isn't: https://podcasts.apple.com/tr/podcast/risk-adjustment-reality-check-whats-working-and-what-isnt/id1641739619?i=1000751388696
- Pinson and Tang, "Functional Quadriplegia: Not Due to Spinal Cord Injury": https://www.pinsonandtang.com/resources/functional-quadriplegia-not-due-to-spinal-cord-injury/

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One Norwood Auditor = Outsized Returns

One good, highly skilled inpatient coding auditor with a fresh perspective and broad experience can deliver outsized returns for your healthcare organization. We have a great example.

A large, integrated healthcare organization was missing these in the documentation:

- **Justified secondary diagnoses**
- **Properly sequenced principal diagnoses**

The Result? Underrepresentation of its severity of illness/risk of mortality, and diminished revenue. All confirmed via independent audit.

Norwood partnered to provide a seasoned, credentialed, and skilled inpatient coding auditor to help right the ship.
The numbers over nine months of work tell the story:

Making an Impact: One Norwood Auditor

Month	Cases Audited	DRG Recommendation	DRG Turnover Rate	Reimbursement Impact
July	147	37	25%	$295,000
August	187	43	23%	$167,000
September	153	31	20%	$129,000
October	154	28	18%	$130,000
November	146	34	23%	$223,000
December	169	31	18%	$200,000
January	163	36	22%	$182,000
February	136	18	13%	$85,000
March	118	21	18%	$118,000
Total	**1,373**	**279**	**20%**	**$1,529,000**

The Takeaways?

An external auditor sees the chart differently than your staff.

Great people remain your biggest difference makers and are irreplaceable

We're your partner in on-demand talent.

Partner with Norwood

Why work with us? Our On-demand Talent is our difference.

We provide concrete data and regular reporting to demonstrate impact and ROI.

You'll experience peace of mind with our unmatched levels of transparency and service.

Contact us today at info@norwood.com.