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# Coding in the Gray

## Why Human Judgment Still Matters

COPD

Sepsis

Present on Admission

Class 3 vs Morbid Obesity

Major Depressive Disorder

**5 Complex Coding Scenarios**

Part 2 of 2

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# Coding in the Gray: Part 2
## Introduction


In Part 1 of Coding in the Gray we explained why "autonomous coding" is a misnomer. No coding system is fire and forget.

Following are five additional scenarios that put on full display why you still need humans, and human auditors, backstopping your coding and CDI programs.

For example, how would automous coding handle physicians who don't want to document "morbid obesity" due to patient stigma? We submit massive severity would be left on the table.

What would happen to your organization deploying an autonomous AI solution that overcaptured sepsis and drove up your hospital's readmission rates for the diagnosis —and corresponding financial penalties and audit profile?

Should you need an audit partner who errs on the side of compliance and works with some of the best people in the business, consider Norwood.

We're here for you when you need us.

In the meantime we hope you enjoy the second of this two-part series. If you have any additional "gray" coding scenarios to send my way, hit me up anytime. Part 3 is not out of the question.

All the best,
Brian Murphy, Norwood
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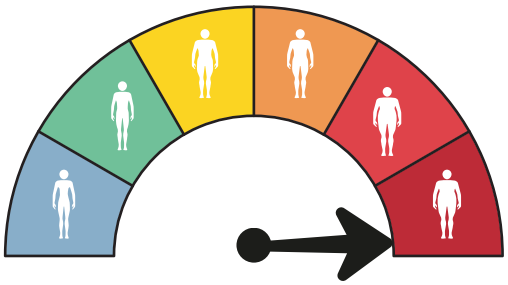
# Class 3 vs. Morbid Obesity

## Scenario 6

A mid-revenue cycle professional lamented on a recent call that their CDI program is hindered because physicians don't want to diagnose "morbid obesity." It has become a fraught term, seen as demeaning to the patient. I get it.



The good news is, Class 3 obesity has come to the rescue.

Or has it?

Are providers documenting "Class 3 obesity"? Not in all cases, it seems.

Provider documentation habits take a long time to change and new terminology does not get accepted overnight. Class 3 has been around for a few years but still isn't fully adopted.

### What is Class 3 Obesity?

*previously known as Morbid Obesity*

**It is the most severe category of obesity**

**It is a high-risk, chronic disease that significantly increases the risk of mortality, heart disease, diabetes, and cancer**

*And it's a CC, impacting payment*

Learn more about Class 3 Obesity, through the helpful article from the Cleveland Clinic (see link below).

**The definition of Class 3 Obesity in simplest terms is:**

## BMI of 40 or Greater

Class 3 Obesity is recognized as a complex chronic disease rather than a personal failure, with treatment focused on reducing metabolic risks and improving long-term health.

### Weight Metric

This often corresponds to being roughly 100 pounds or more over ideal body weight

### Treatment

Due to its severity, treatment often involves a combination of medical supervision, lifestyle changes, weight-loss medications, and potential bariatric surgery.

### Health Risks

High risk for cardiovascular disease, type 2 diabetes, stroke, fatty liver disease, and certain cancers.

Let's look at what the 2026 ACDIS Pocket Guide has to say.

Although the Cleveland Clinic article implies Class 3 has replaced morbid, there are separate ICD-10-CM codes for each, and a subtle difference in the definition.

- **Morbid obesity → E66.01**
- **Class 3 obesity → E66.813**

The difference? Morbid obesity is BMI of 40 or greater; OR a BMI of 35 or greater with at least one weight-related comorbidity (e.g., severe sleep apnea, diabetes, GERD, hypertension, arthritis).

But payment implications SOI/ROM are the same. Both conditions when reported with BMI scores are CCs; both group to CMS-HCC 48. They also have impact in quality measure risk adjustment including the Elixhauser Comorbidity Index.

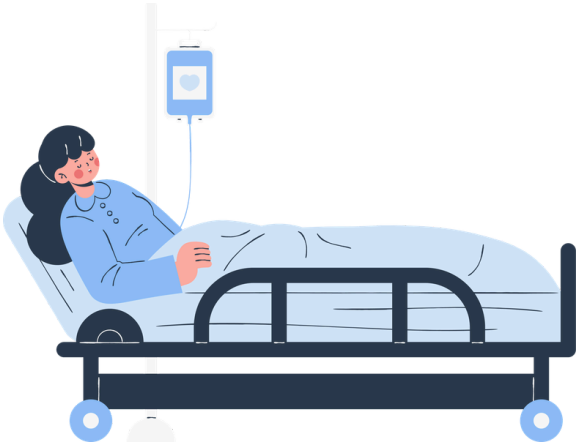
The Pocket Guide adds that the physician should document the relationship between the patient's weight and comorbid conditions, as this clinically validates the presence of morbid obesity. The linkage offers stronger support for reporting.

Don't be fooled into thinking a BMI is enough to report obesity. The provider still must document obesity with specificity.

## Question For You:

- **Do you see any meaningful difference between morbid obesity and Class 3?**
- **Has Class 3 obesity become a standard of documentation in your organization? Have you had any organizational initiatives to make this the new standard?**
- **Do your providers still prefer morbid obesity–and if so, is there a reluctance to document it?**
- **And finally, do payers accept Class 3 as synonymous with morbid?**

# Present on Admission
## Scenario 7



Present on admission (herein POA) for coding purposes is defined as conditions that are present at the time the order for the inpatient admission occurs.

It's important to get POA status right, as it impacts payment and quality metrics. POA conditions (as reported with a Y) count as CCs or MCCs, whereas conditions that develop in the hospital are not (these are healthcare-acquired conditions, or HACs).

Some commercial payers may vary.

### Here are 5 "Gray" Things to Keep in Mind when reporting POA

1

**POA is more forgiving than you might believe**

POA conditions can develop in an outpatient encounter, for example in your ED or during surgery, necessitating admission. These are still POA. POA does not mean a condition that occurred after passing the threshold of a hospital door; it's the time of the IP order that matters. Cool.

**It's OK for your physicians to be uncertain and report uncertainty in their note**

(in fact, Y and N are for explicit documentation only).
We have a POA status for that—W.

2

W is clinically undetermined, reported when a provider is unable to clinically determine whether a condition is POA. Payment is made if the diagnosis is a HAC.

3

**The ICD-10-CM Official Guidelines for Coding and Reporting contain a wealth of documentation scenarios for the many gray areas of POA, and thus should be reviewed at least annually.**

For example, of Codes that Contain Multiple Clinical Concepts, the guidelines state, "Assign "N" if at least one of the clinical concepts included in the code was not present on admission (e.g., COPD with acute exacerbation and the exacerbation was not present on admission; gastric ulcer that does not start bleeding until after admission; asthma patient develops status asthmaticus after admission)."

**U (Unknown; documentation insufficient to determine POA status) should be used very sparingly.**

Your CDI team and/or coders should query the provider when the documentation is unclear. Excessive use of U should lead to focused documentation training and an effort to drive that rate down. Keep an eye on that.

4

5

**No time frame is required for a provider to identify/document a condition as POA or no.**

Per the Official Coding Guidelines, it may not always be possible for a provider to immediately make a definitive diagnosis; alternatively, a patient may not recognize or report a condition until well into a patient's admission.

"In some cases, it may be several days before the provider arrives at a definitive diagnosis. This does not mean that the condition was not POA."

**How is your POA reporting?**

**Do physicians understand the use and ramifications of U, or W?**

***Any interesting POA scenarios?***

# Major Depressive Disorder
## Scenario 8

Medscape recently published "Adjunctive Antipsychotics for Major Depressive Disorder (MDD) Ranked." Not a wildly inspiring article title. And I know nothing about adjunctive antipsychotics. But then I started thinking…

**MDD is a CMS-HCC under v28 (HCC 155 – Major Depressive, Bipolar, and Paranoid Disorders, 0.388 RAF/community non dual aged).**

So we have care funding implications … and therefore audit/risk adjustment data validation (RADV) implications.

One way to strengthen diagnosis and lessen audit vulnerability: Marry diagnosis with treatment in the documentation. In this case, medication.

Most are used to seeing drugs like Prozac or Zoloft in association with MDD. This study includes an analysis on the efficacy of five "atypical" antipsychotics: aripiprazole, brexpiprazole, cariprazine, lumateperone, and quetiapine extended release (XR).

These are five FDA-approved antipsychotic adjunctive therapies for adults with MDD who had an inadequate response to antidepressant treatment alone.

You don't have to know everything about these drugs and how they differ (I certainly don't), but if you're in the mid-revenue cycle/risk adjustment you should know what they point toward.

Something to share with your CDI/coding teams.
Or pass along to your AI/NLP vendor.
Because the dx is under scrutiny.

**Per my colleague Jason Jobes, analysis of MDD taken from OIG audit data from 2022-2024 show the diagnosis has an 80% compliance rate...**

**Meaning 20% of submissions had insufficient documentation and did not stand up to audit.**

***MDD actually performed better than many other risk-adjusted diagnoses … but that doesn't mean it's not vulnerable.***

**We still need documentation.**

## Examples That Typically Matter for MDD:

- Major depressive disorder, recurrent, severe
- MDD with psychotic features
- Bipolar-related depressive conditions
- Schizoaffective/depressive spectrum diagnoses

## As for RADV Exposure: Behavioral Health Diagnoses are a Meaningful Audit Focus. Why?

- Diagnoses can be subjective
- Documentation quality is inconsistent
- MEAT criteria are often weak
- Some diagnoses persist on problem lists without active management

CMS auditors typically want to see evidence that the condition met MEAT criteria. So for depression, that might mean medication management and treatment response discussion.

## Common vulnerabilities for MDD include:

- diagnosis documented only in history/problem list
- lack of active assessment or treatment
- no evidence of medication management or follow-up
- unspecified severity
- coding from screenings alone (PHQ-9 without provider assessment)

**MDD was described as a "High Risk Diagnosis" in a September 2022 OIG Audit of Highmark Senior Health Company.**

The OIG stated that of 30 sampled enrollee years for the DX, 8 were in error (a 27% error rate). The OIG then offered an example of what it considered to be an error —no documented treatment:

An enrollee received one major depressive disorder diagnosis (which maps to the HCC for Major Depressive, Bipolar, and Paranoid Disorders) during the service year but did not have an antidepressant medication dispensed on his or her behalf.

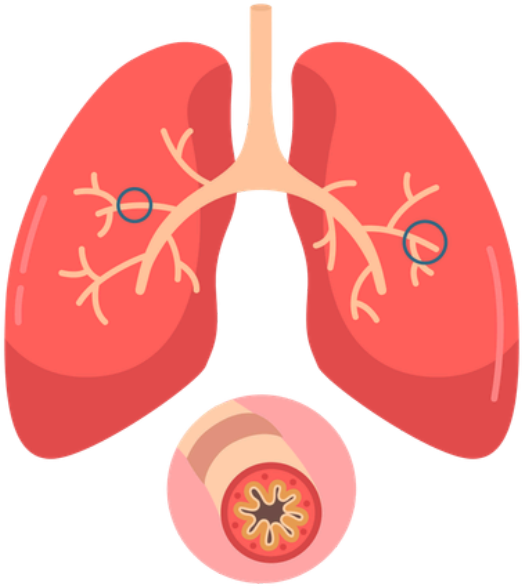
In these instances, the major depressive disorder diagnoses may not be supported in the medical records.

Drug presence alone does not determine the HCC. The actual documented diagnosis and ICD-10 code do. However, these drugs can support clinical validity for severe or recurrent depression diagnoses.

**Have you seen any of these new drugs in the documentation?**

**Do you have any issues with MDD?**

# COPD
## Scenario 9



Are you following the GOLD standard for COPD (Chronic Obstructive Pulmonary Disease) diagnosis and management?

Medscape has a great article and video on this underreported diagnosis by Dr. Neil Skolnik. See link below. Here's why I recommend it.

As always with articles of this sort I caveat that I'm not a clinician and I have a lapsed coding credential.

Your interpretations may vary and I certainly welcome your input, disagreement, etc.

1

**COPD is Hugely Under-diagnosed**

and therefore improved capture is almost certainly an opportunity for your organization. Per Medscape, 80% of people with COPD do not have that diagnosis made. "We should have a low threshold for testing for COPD," Dr. Skolnik concludes.

**It Offers Clinical Indicators For the CDI or Coder**

Per Medscape, if an older person has shortness of breath (either with exertion or rest), chronic cough, heavy sputum production or severe upper respiratory illnesses, think about possible COPD. Get that query going.

2

3

**It Has What is Needed for Diagnosis (and therefore, coding).**

Confirm COPD with in-office spirometry or formal pulmonary function tests. Look for the presence of non-fully reversible airflow obstruction, which GOLD defines as an FEV1-to-FVC ratio of < 0.7 on postbronchodilator testing.

**It has what is needed for documentation support (and therefore, compliant billing).**

COPD is unfortunately irreversible, which is what makes it COPD … but not in the eyes of insurers. Recall that risk adjustment diagnoses "reset" each Jan. 1, and providers not only have to see the patient in a face-to-face encounter to report the diagnosis, but also meet a minimum documentation standard. Get that smoking assessment and CBC order in for MEAT.

4

5

**It arms you against denials.**

Payers love to grab and employ whatever criteria they can to deny a diagnosis. If you're using some other standard they may use GOLD against you. This is an international standard and it seems to me should be your organizational standard as well. If payers aren't using GOLD, you can back up yours with the "gold standard" (ahem).

**It has what is needed for ongoing treatment (and therefore, value for clinicians).**

Don't just make it about documentation and coding; incorporate this into your CDI/coding education.

6

COPD has quality and payment ramifications.
Since I also have a fresh copy 2026 ACDIS Pocket Guide let's see what that says.

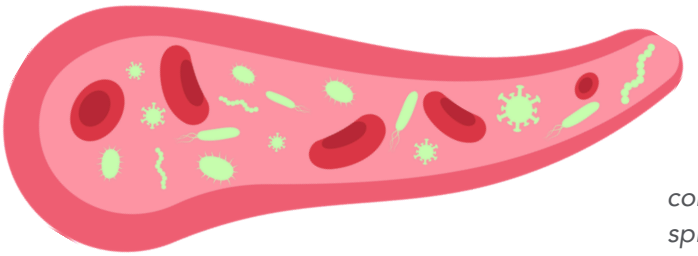
**COPD with acute exacerbation codes to J44.1; COPD with acute lower respiratory infection codes to J44.0**

Both are CCs. Both map to HCC 280 (relative weight 0.319) and also impact quality including readmission (HRRP) and 30-day mortality models.

**Capturing COPD with an exacerbation or associated infections is critical for direct and indirect reimbursement and quality scores.**

# Sepsis
## Scenario 10

The Great Sepsis War rages on. The infection itself, which kills hundreds of thousands every year, but also in the hallowed halls of coding classification.



**Where in the A41.9 will we end up with this deadly but controversial infection?**

*(Aside: Sepsis isn't funny, but the rage elicited over conflicting definitions and the sheer volume of digital ink spilled on this dx is a bit humorous. You must know this).*

I heard some folks say "game over" when the Government Accountability Office issued a report (see below) that seemed to champion sepsis-3.

Wrong.

**Sepsis-2 still being used widely,**
*for good reasons. It's:*

- **Better at capturing early sepsis.**
- **Better aligned with CMS's own sepsis core measures, which is now being used in the Hospital Readmission Reduction Program (HRRP).**

I hosted a frontline sepsis care nurse on Off the Record (link below, you should listen, fantastic episode) who confirmed the pressing clinical need to catch sepsis early before it comes a five-alarm fire—and just how much hospital resources are expended to treat a diagnosis that would not meet the strict qualifications of sepsis-3. Sepsis comprises a continuum for her organization, which still uses sepsis-2.

The debate rages on.

BUT… now we've got a big POSSIBLE (use of all caps deliberate) change afoot. Nothing has been approved, but a big proposal was made at an ICD-10-CM Coordination and Maintenance Committee Meeting in March, with additional information coming in September 2026.

This change attempts to end the Great Sepsis War by moving us firmly into the sepsis-3 camp, while also addressing the issue of impending/early sepsis. Link to the proposal below, see pp. 89-90. From that:

"It is proposed to create an expansion of sepsis codes, to identify (by organism) sepsis and impending sepsis, with at this time a single example given. Also, it is proposed to create codes to identify the organ dysfunction present, while also deleting the severe sepsis code and terminology, based on the definitional changes in Sepsis 3."

**We get proposed tabular modifications to just A41.9, but with the note that the same approach, if approved, would need to be applied to 40 additional sepsis codes.**

These include:

**Revise Current: A41.9**

"Sepsis, unspecified organism" to read "Sepsis and impending sepsis, unspecified organism."

**New code: A41.91**

"Sepsis, specified organism"

(many such specific examples listed).

**New code: A41.92**

"Impending sepsis, unspecified organism."

**The proposal also calls for a revision to R65.2, "Severe sepsis,"**

as follows:

**R65.2**

"Organ dysfunction associated with sepsis."

**Proposed Deletion: R65.20**

"Severe sepsis without septic shock."

**Proposed Revision: R65.21**

currently "severe sepsis with septic shock," revise to "Septic shock."

Some are opposed, saying that the Cooperating Parties should not be in the business of practicing medicine, and that this is a bridge too far.

I think this might be a good fix, for reasons noted above. but I also could be wrong. But as for now, sepsis remains firmly in the gray, requiring human judgement to sort it all out.

# References & Resources


- ACDIS, 2026 Pocket Guide
- ACDIS, Q&A, Class 3 Obesity: https://acdis.org/articles/qa-class-3-obesity
- CDC, ICD-10 Coordination and Maintenance Committee Meeting, March 17-18, 2026 ICD-10-CM Diagnosis Agenda: https://www.cdc.gov/nchs/data/icd/topic-packet-March-2026.pdf (see pp. 89-90)
- Cleveland Clinic, "Class III Obesity (Formerly Known as Morbid Obesity": https://my.clevelandclinic.org/health/diseases/21989-class-iii-obesity-formerly-known-as-morbid-obesity
- CMS, ICD-10-CM Official Guidelines for Coding and Reporting (note: POA guidelines start on p. 116): https://www.cms.gov/files/document/fy-2026-icd-10-cm-coding-guidelines.pdf
- GAO, Defense Health Care: Information on Sepsis Incidence and Management: https://www.gao.gov/assets/gao-25-107357.pdf
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- Jason Jobes, OIG High Risk Conditions- Only 23.9% of high-risk diagnoses reviewed by the OIG have sufficient documentation: https://www.linkedin.com/posts/jason-jobes-norwood_oig-high-risk-conditions-only-239-of-high-activity-7278445527589875712-8HHQ/
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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.**

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