ICD-10 Troubleshooting: Inpatient/Outpatient
Tips from Coders to Coders

Spring 2016
About the Presenter

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Stacy joined RMC in 2006, and is currently Regional Coding Manager. In this role Stacy performs coding quality reviews for RMC’s internal staff and Clients. Stacy has over 20 years’ experience in the Health Information Management field and has held various positions of Coder, Coding Compliance Coordinator and HIM Director. Stacy is multi-talented with inpatient and outpatient skills and a wonderful educator and trainer. Stacy has been a vital part of development and implementation RMC’s ICD-10 training program and participates in ongoing teaching of staff and clients. Stacy enjoys conducting audits, researching coding issues, and providing education to coders. Stacy recently completed her Associates Degree in HIM and passed her RHIT exam in May 2016. Stacy is an AHIMA approved ICD-10-CM/PCS Trainer with experience in coding and auditing of ICD-10-CM and PCS. Additionally, Stacy is an active member of AHIMA, TxHIMA, & HAHIMA.
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So... How are YOU doing??

Photo Credit: Connie Calvert
ICD 10 Post Implementation

F43.20
Adjustment disorder
ICD-10 – Does the Fun Ever Stop?

- Dual coding
- Questions coming in
- Didn’t know what we didn’t know
- Now finding the gaps
- Differences, similarities, challenges
- Where do we go for answers??
  - Guidelines
  - ICD 10 Handbook
  - Coding Clinic
  - Peers/Colleagues

**Be prepared for revisions – changes to advice**
Guidelines and Conventions
Excludes 1

Please see the "Interim advice on excludes 1 note on conditions unrelated" (next slide) posted to the NCHS website with the ICD-10-CM guideline documents. Apparently Excludes1 does not ALWAYS mean the 2 conditions cannot be reported together.....they cannot be reported together when they are RELATED. But if unrelated, per this document, they can still both be reported.

Ref: Coding Clinic, Fourth Quarter 2015: Page 40
In 2012, Coding Clinic’s for ICD-10-CMS/PCS began. Every effort was made to carry over the ICD-9-CM guidelines and concepts into ICD-10-CM, unless there was a specific change in ICD-10-CM that precluded the incorporation of the same concept into ICD-10-CM. However, some of the guidelines in ICD-9-CM included information that may have been clinical in nature and therefore not appropriate for coding guidelines.

However, there are no plans to translate all previous issues of Coding Clinic for ICD-9-CM into ICD-10-CM/PCS since many of the questions published arose out of the need to provide clarification on the use of ICD-9-CM and would not be readily applicable to ICD-10-CM/PCS. Care should be exercised as ICD-10-CM has new combination codes as well as instructional notes that may or may not be consistent with ICD-9-CM.
Applying Past Issues of Coding Clinic for ICD-9-CM to ICD-10-CM

• In general, clinical information and information on documentation best practices published in Coding Clinic were not unique to ICD-9-CM, and remain applicable for ICD-10-CM with some caveats. For example, Coding Clinic may still be useful to understand clinical clues when applying the guideline regarding not coding separately signs or symptoms that are integral to a condition. Users may continue to use that information, as clues—not clinical criteria.

• As far as previously published advice on documentation is concerned, documentation issues would generally not be unique to ICD-9-CM, and so long as there is nothing new published in Coding Clinic for ICD-10-CM and ICD-10-PCS to replace it, the advice would stand.

• Every attempt was made to remain as consistent with the ICD-9-CM guidelines as possible, unless there was a change inherent to the ICD-10-CM classification.

For more information Ref: Coding Clinic, Fourth Quarter 2015: Page 20
Code Set Freeze

There are no new/revised ICD-10-CM diagnosis codes, or changes to the ICD-10-CM Official Guidelines for Coding and Reporting for fiscal year (FY) 2016, because of the partial code set freeze in preparation of ICD-10 implementation. The following link is to the current ICD-10-CM guidelines:


Effective October 1, 2015, there have been limited code updates to the ICD-10-PCS code sets to capture new technologies as required by section 503(a) of Pub. L. 108-173. The ICD-10 Coordination and Maintenance Committee has continued to meet twice yearly during the partial freeze. At these meetings, the public agreed that new ICD-10-PCS procedure codes should be created based on the need to capture new technology. On October 1, 2016 (one year after implementation of ICD-10), regular updates to ICD-10-CM and ICD-10-PCS will begin.
DRG Shift

DRG 795 Normal Newborn

- In ICD-9-CM, when a newborn is monitored for signs following maternal chorioamnionitis, the diagnosis code assigned is V29.0
  - Per ICD-9 Guidelines, codes from Category V29 are used to identify those instances where further evaluation or care is given to a newborn because of a potential problem without diagnosis. This category is to be used when newborns are suspected to be at risk for an abnormal condition resulting from exposure from the mom or birth process without signs or symptoms which requires study but after examination and observation, it is determined that there is a no need for further treatment or medical care.

DRG 794 Neonate with other significant problems

- In ICD-10-CM, when a newborn is monitored for signs following maternal chorioamnionitis, the diagnosis code assigned is P02.7
  - Per ICD-10 Guidelines, codes from Category P00-P004 are used for newborns who are suspected of having an abnormal condition resulting from exposure from the mom or birth process but without signs or symptoms, and which after exam and observation, is found not to exist. These codes may be used even if treatment is begun for a suspected condition that is ruled out.
DRG Shift

All DRGs without CC

• In ICD-9 when the physician documents “bacteriuria, asymptomatic bacteriuria without urinary tract infection” diagnosis code 791.9 is assigned
  – This is not a CC

All DRGs with CC

• In ICD-10 when the physician documents “bacteriuria, asymptomatic bacteriuria” diagnosis code N39.0 is assigned.
  – This is a CC
CC/MCC Changes

- MDD no longer a CC
- Malignant HTN no longer MCC
- Schatzki’s ring not MCC
  - Now defaults to “Acquired” – opposite of I-9
  - “Congenital” is still an MCC
- New CCs: Persistent A Fib, Mild malnutrition, nicotine withdrawal
ICD-10-CM
Retained Myringotomy Tubes

When myringotomy tubes are placed it is expected that they will eventually fall out on their own without any intervention as part of the natural course. However occasionally these tubes do not fall out and will require removal by the provider. Therefore documentation of “retained” myringotomy tube would be coded as a mechanical complication - T85.698A would be the appropriate code.
Alcohol Intoxication without Documentation of Abuse

Alcohol intoxication automatically defaults to alcohol abuse with intoxication per the Alphabetic Index. Follow index for guidance. If ETOH intoxication is solely documented, this leads to F10.129, Alcohol Abuse with Intoxication. However, if alcohol dependence was documented then based on the hierarchy, dependence would be used which is coded to F10.229.
Alcohol withdrawal with Documentation of Abuse

Per Coding Clinic 2\textsuperscript{nd} Q, 2015, pg. 15 “In ICD-10-CM, alcohol withdrawal is categorized as alcohol dependence, by default. The classification provides a combination code for alcohol dependence with alcohol withdrawal. Therefore QUER\textsc{Y} the provider for clarification, when alcohol abuse and alcohol withdrawal are both documented in the health record.”
Hematuria Due to Traumatic Foley Catheter Placement

This scenario would require 3 codes:
T83.83XA Hemorrhage of genitourinary prosthetic devices, implants and grafts, initial encounter.
R31.9 Hematuria, unspecified
Y84.6 Urinary catheterization as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at time of the procedure.

See Instructional Notes T80 - T88 - Use additional code to identify specific condition resulting from the complication (hematuria)
Pneumonia with Hemoptysis

ICD-9

- AHA ICD-9 Coding Clinic, Third Quarter 2011, page 12 states symptoms codes are not assigned when they are implicit in the diagnosis or when the symptom is included in the code for the condition.
- The term “hemorrhagic” is shown in the Alphabetic Index as a nonessential modifier for pneumonia. “Hemorrhagic” as a nonessential modifier or supplementary term indicates that any bleeding should not be coded separately.
- Hemoptysis is not coded in ICD-9

ICD-10

- AHA Coding Clinic, 4th Quarter 2013 page 118 states hemoptysis (code R04.2) can be assigned as an additional code when the condition occurs with pneumonia. Although code R04.2 is a Chapter 18 code, codes for signs and symptoms may be reported in addition to a related definitive diagnosis when the sign or symptom is not routinely associated with the diagnosis.
- Hemorrhagic is no longer an essential modifier for pneumonia in the ICD-10-CM index to diseases.
- Hemoptysis is a “cc” and will affect reimbursement
Diabetes with Associated Conditions

Per the Official Coding Guidelines for ICD-10-CM, the term "with" means "associated with" or "due to," when it appears in a code title, the Alphabetic Index, or an instructional note in the Tabular List.

ICD-10-CM assumes a cause-and-effect relationship between diabetes and certain diseases of the kidneys, nerves, and circulatory system. These assumed cause-and-effect relationships may differ between ICD-9-CM and ICD-10-CM.

- **Do not code as a Diabetic complication if documentation clearly states that a condition other than diabetes is the cause.**

Reference: Coding Clinic 1Q 2016, Page 11
Diabetes with Associated Conditions

Diabetes, type 2 E11.9

with

- amyotrophy E11.44
- arthropathy NEC E11.618
- autonomic (poly) neuropathy E11.43
- cataract E11.36
- Charcot's joints E11.610
- chronic kidney disease E11.22
- circulatory complication NEC E11.59
- complication E11.8
  - specified NEC E11.69
- dermatitis E11.620
- foot ulcer E11.621
- gangrene E11.52
- gastroparesis E11.43
Diabetes with Associated Conditions

- glomerulonephrosis, intracapillary E11.21
- glomerulosclerosis, intercapillary E11.21
- hyperglycemia E11.65
- hyperosmolarity E11.00
  - with coma E11.01
- hypoglycemia E11.649
  - with coma E11.641
- ketoacidosis (Coding Clinic for ICD-9-CM 1Q 2013) E13.10
  - with coma (Coding Clinic for ICD-9-CM 1Q 2013) E13.11
- kidney complications NEC E11.29
- Kimmelsteil-Wilson disease E11.21
- mononeuropathy E11.41
- myasthenia E11.44
- necrobiosis lipoidica E11.620
- nephropathy E11.21
- neuralgia E11.42
Diabetes with Associated Conditions

- neurologic complication NEC E11.49
- neuropathic arthropathy E11.610
- neuropathy E11.40
- ophthalmic complication NEC E11.39
- oral complication NEC E11.638
- periodontal disease E11.630
- peripheral angiopathy E11.51
  - with gangrene E11.52
- polyneuropathy E11.42
- renal complication NEC E11.29
- renal tubular degeneration E11.29
Diabetes with Associated Conditions

- retinopathy **E11.319**
  - with macular edema **E11.311**
  - nonproliferative **E11.329**
    - with macular edema **E11.321**
    - mild **E11.329**
      » with macular edema **E11.321**
    - moderate **E11.339**
      » with macular edema **E11.331**
    - severe **E11.349**
      » with macular edema **E11.341**
  - proliferative **E11.359**
    - with macular edema **E11.351**
- skin complication NEC **E11.628**
- skin ulcer NEC **E11.622**
Diabetes with Osteomyelitis

ICD-9

- Per AHA Coding Clinic, First Quarter 2004, page 14-15 “ICD-9-CM assumes a relationship between diabetes and osteomyelitis when both conditions are present, unless the physician has indicated in the medical record that the acute osteomyelitis is totally unrelated to the diabetes.”

ICD-10

- Per AHA Coding Clinic, Fourth Quarter 2013, page 114, ICD-10-CM does not presume a linkage between diabetes and osteomyelitis. The provider will need to document a linkage or relationship between the two conditions before it can be coded as such.
Dehydration with Hypo/Hypernatremia

ICD-9

• When viewing the Alphabetic Index, “dehydration” indexes to 276.51.
• There are indentations with the subentry terms “with hypernatremia 276.0” and “with hyponatremia 276.1.
• Only 1 code is assigned.

ICD-10

• According to AHA Coding Clinic, First Quarter 2014, page 7 two codes are required to fully capture dehydration with hypernatremia (E86.0 and E87.0) and dehydration with hyponatremia (E86.0 and E87.1).
• Coders should follow the index, which leads to coding both the dehydration and hypernatremia/hyponatremia separately.
SIRS Due to Pneumonia Without Sepsis

ICD-9

• Per AHA Coding Clinic, Fourth Quarter 2003, page 79-81 if the terms sepsis, severe sepsis, or SIRS are used with an underlying infection other than septicemia, such as pneumonia, cellulitis or a non-specified urinary tract infection, code 038.9 should be assigned first, then code 995.91, followed by the code for the initial infection. This is because the use of the terms sepsis or SIRS indicates that the patient's infection has advanced to the point of a systemic infection so the systemic infection should be sequenced before the localized infection.

ICD-10

• According to AHA Coding Clinic, Third Quarter 2014, page 4 if the provider lists “SIRS secondary to pneumonia” in his diagnostic statement assign only code J18.9 (Pneumonia, unspecified organism).

• When sepsis is not present, no other code is required. The ICD-10-CM does not provide a separate code or index entry for SIRS due to an infectious process.

• If the health record documentation appears to meet the criteria for sepsis, the provider should be queried for clarification. Encoders are tools that may assist coders; however the codes must be validated and supported by the health record documentation.
Rehab

• In ICD-10 there is no equivalent for V57.89
• The sequelae of the CVA would be the principal diagnosis
• If patient is admitted to rehab following an injury, the fracture code would be assigned as the principal diagnosis with the appropriate 7th character (subsequent encounter). Do not assign an aftercare Z code.
• If a patient is admitted to a nursing home for deconditioning, code the symptoms of the deconditioning, such as gait disturbance, weakness, etc.
**Rehab**

- If the admission to rehab is strictly for convalescence and there is no other definitive diagnosis, assign code Z51.89 (Encounter for other specified aftercare), as the first-listed diagnosis.

- If the patient was transferred to a nursing home for convalescence and strengthening following coronary artery bypass surgery assign code Z48.812, Encounter for surgical aftercare following surgery on the circulatory system), as the principal diagnosis. The condition that was treated surgically if still present would be coded. Assign also codes for any symptoms such as weakness, gait disturbance, pain, etc., as additional diagnoses. You may also assign Z95.1, presence of aortocoronary bypass graft, to indicate the surgery for which aftercare is being performed.

*See Coding Clinic, Fourth Quarter 2012 page 90 and Fourth Quarter 2013 page 127 for other examples*
Decompensated Heart Failure

• The general definition of decompensated can be applied when assigning ICD-10-CM codes as well.

• The appropriate diagnosis code for documentation of “chronic systolic heart failure, currently decompensated” would be code I50.23 (Acute on chronic systolic heart failure, for decompensated systolic heart failure).

• See Coding Clinics, Second Quarter 2013, page 33 and Third Quarter 2008, page 12
Question:

*Coding Clinic*, Third Quarter 2008, p. 12, states “decompensated indicates that there has been a flare-up (acute phase) of a chronic condition.”

Should this general definition of decompensated be applied when assigning ICD-10-CM codes as well? For example, what is the appropriate ICD-10-CM code assignment for a diagnosis of chronic systolic heart failure, currently decompensated?
Answer:
Assign code I50.23, Acute on chronic systolic heart failure, for decompensated systolic heart failure.
As previously stated, “decompensated” indicates that there has been a flare-up (acute phase) of a chronic condition.
Watch Out For!

- Per AHA Coding Clinic, Fourth Quarter 2014, page 21 the physician documents “right heart failure, decompensated cor pulmonale secondary to severe pulmonary hypertension” in his final diagnostic statement. How should acute cor pulmonale be coded when there is no documentation of pulmonary embolism?
Watch Out For!

- Assign secondary diagnosis code I27.81 (Cor pulmonale, chronic) and I27.2.
- ICD-10-CM’s Index references code I27.2 under “pulmonary hypertension with cor pulmonale.” Unfortunately, the Index under “pulmonary hypertension with acute cor pulmonale” leads to code I26.09, Other pulmonary embolus with acute cor pulmonale. In this case, code I26.09 is not appropriate since the patient does not have a pulmonary embolism.
- The National Center for Health Statistics (NCHS), the organization responsible for ICD-10-CM, will consider a future C&M proposal to modify the codes describing pulmonary embolism with cor pulmonale.
Ulcers of Skin with Gangrene

L89 & L97

***Assign I96 first when gangrene is present***

Ex) I96 + L89.153 – Sacral PU stg 3 w/ gangrene

When gangrene present with ulcer or injury, code gangrene 1st, followed by code for ulcer/injury as additional code. See Instructional Notes in Tabular

Cellulitis described as gangrenous is classified to I96.
Tabular Example

L89 Pressure ulcer
Includes: bed sore
decubitus ulcer
plaster ulcer
pressure area
pressure sore
Code first any associated gangrene (I96)
**Tabular Example**

**L97 Non-pressure chronic ulcer of lower limb, not elsewhere classified**

**Includes:** chronic ulcer of skin of lower limb NOS
non-healing ulcer of skin
non-infected sinus of skin
trophic ulcer NOS
tropical ulcer NOS
ulcer of skin of lower limb NOS

**Code first any associated underlying condition, such as:**

any associated gangrene (**I96**)
atherosclerosis of the lower extremities (**I70.23-**, **I70.24-**, **I70.33-**, **I70.34-**,
**I70.43-**, **I70.44-**, **I70.53-**, **I70.54-**, **I70.63-**, **I70.64-**, **I70.73-**, **I70.74-**)
chronic venous hypertension (**I87.31-**, **I87.33-**)
postphlebitic syndrome (**I87.01-**, **I87.03-**)
postthrombotic syndrome (**I87.01-**, **I87.03-**)
varicose ulcer (**I83.0-**, **I83.2-**)

**Excludes2:** pressure ulcer (pressure area) (**L89-**)
skin infections (**L00-L08**)
specific infections classified to **A00-B99**


**Tabular Example**

**I96**  Gangrene, not elsewhere classified

Gangrenous cellulitis

**Excludes1:** gangrene in atherosclerosis of native arteries of the extremities (I70.26)

gangrene in diabetes mellitus (E08-E13)

gangrene in hernia (K40.1, K40.4, K41.1, K41.4, K42.1, K43.1-, K44.1, K45.1, K46.1)

gangrene in other peripheral vascular diseases (I73.-)

gangrene of certain specified sites - see Alphabetical Index

gas gangrene (A48.0)

pyoderma gangrenosum (L88)
Osteomyelitis, Toe

- You can only code what is specifically documented; in this particular case correct code would be Osteomyelitis unspecified M86.9. Unfortunately since not documented as acute or chronic, toe is not an option
- CDI issue.
Index Example

Osteomyelitis (general) (infective) (localized) (neonatal) (purulent) (septic) (staphylococcal) (streptococcal) (suppurative) (with periostitis) \textbf{M86.9}

- acute \textbf{M86.10}
  - toe \textbf{M86.17-}
- chronic (or old) \textbf{M86.60}
  - toe \textbf{M86.47-}
Reversal of Lordosis

The anatomy of the neck features a lordotic curvature in its typical and healthy state. Reversal of the curvature means that part or all the cervical spine develops a kyphotic profile. Lordosis is normal and expected in the cervical spine, as opposed to other areas of the spine (thoracic, lumbar). Because there are many conditions which could cause reversal of lordosis, such as scoliosis, spondylolisthesis, and because reversal of lordosis is not an actual diagnosis, the most appropriate code in this case would be R93.7, Abnormal findings on diagnostic imaging of other parts of musculoskeletal system.
Disc Osteophyte Complex

RMC Question:

• How are we supposed to code “disc osteophyte complex para-centrally on the left at C6-C7”
Disc Osteophyte Complex

Answer:

• Disc osteophyte complex occurs when soft disc tissue between vertebrae begins to breakdown. The tissue can calcify, harden and place pressure on bone.

• Code Osteophyte, spine/vertebra - M25.78 would not be appropriate as the growth is not of the vertebrae itself, but a result of the disc/soft tissue between the vertebrae. Therefore, at this time, it appears the most appropriate code is M50.92, Cervical disc disorder, unspecified, mid cervical region.
Cervical Disc Disorders

• Coding Clinic 1Q 2016, pg 17

• Regarding the instructional note at Category M50: The intent of the note is to code each disorder at the highest (most superior) level. Each fourth digit subcategory describes a unique disorder, so within each subcategory, code to the highest level. For example, if several regions are affected (e.g., C3-C4 and C5-C6) that are classified to the same subcategory (e.g., M50.0), assign code M50.01, Cervical disc disorder with myelopathy, high cervical region, as C3-C4 is the most superior level.
Cervical Disc Disorders

- M50.0 Cervical disc disorder with myelopathy
  - M50.00 Cervical disc disorder with myelopathy, unspecified cervical region
  - M50.01 Cervical disc disorder with myelopathy, high cervical region
    - C2-C3 disc disorder with myelopathy
    - C3-C4 disc disorder with myelopathy
  - M50.02 Cervical disc disorder with myelopathy, mid-cervical region
    - C4-C5 disc disorder with myelopathy
    - C5-C6 disc disorder with myelopathy
    - C6-C7 disc disorder with myelopathy
  - M50.03 Cervical disc disorder with myelopathy, cervicothoracic region
    - C7-T1 disc disorder with myelopathy
RMC Question:
Which E code would you assign for foreign body in the eye?
I DON'T ALWAYS GET SUCKED INTO A JET ENGINE

BUT WHEN I DO, I USE ICD-10 CODE: V97.33XD
Alcohol Use vs. Withdrawal

Alcohol withdrawal is categorized as alcohol dependence by default

Use, abuse, dependence hierarchy state:

– If both use and abuse are documented, assign only the code for abuse

– If both abuse and dependence are documented, assign only the code for dependence

– If use, abuse and dependence are all documented, assign only the code for dependence

– If both use and dependence are documented, assign only the code for dependence
Alcohol Use vs. Withdrawal

Per AHA Coding Clinic, Second Quarter 2015, page 15, Query the provider for clarification when alcohol abuse and alcohol withdrawal are documented in the chart.

- Our example is for alcohol use but same logic
Stroke with Neurological Deficits

- Per AHA Coding Clinic, First Quarter 2014 page 23, the advice from Coding Clinic, First Quarter 2010 page 5 is still valid.

- Hemiplegia is not inherent to an acute cerebrovascular accident (CVA). Therefore, it should be coded even if the hemiplegia resolves, with or without treatment. The hemiplegia affects the care that the patient receives. Report any neurological deficits caused by a CVA even when they have been resolved at the time of discharge from the hospital.
Weakness due to Previous CVA

• When there is clear documentation that unilateral weakness is associated with a stroke, the weakness is considered synonymous with hemiparesis/hemiplegia.

• Link must be made, no assuming!

• Unilateral weakness associated with some other brain disorder or injury is also synonymous with hemiparesis/hemiplegia.

Ref: Coding Clinic 1st Q 2015: pg 25
Pdx for Vaginal Delivery

- Coders are selecting conditions that arise during the delivery as the principal diagnosis. This is due to misinterpretation of the guideline stating in part, "when a delivery occurs, the principal diagnosis should correspond to the main circumstances or complication of the delivery". The Pdx should be the condition that prompted the admission unless there was no pregnancy complication that prompted the admission, then a complication of delivery can be selected as Pdx.
Congenital Anomalies

- Can have implications for further evaluation and future healthcare needs.
- Codes should be assigned when documented.
- Example: Sacral Dimple: possibly associated with serious underlying abnormalities of spine/spinal cord.
ICD-10-PCS
Vascular Access Devices

Vascular access device is a rather generic term to describe sterile catheter systems used to access a vascular structure either an artery or a vein. Selection of the body part value for insertion of a vascular access device is based on the end placement of the device rather than the point of entry.

- PICC
- CVC with guidance
- CVC without guidance
- Totally Implantable Central VAD

For examples Ref: Coding Clinic, Fourth Quarter 2015: Page 26
Cavoatrial Junction

PICC lines:

• A PICC line is generally inserted in a peripheral vein in the arm (cephalic vein, basilic vein, or brachial vein, and then advanced proximally toward the heart through larger veins, until the tip rests in the distal superior vena cava or cavoatrial junction.

  – Coding Clinic allows the coders to use the imaging report for confirmation of placement.
Cavoatrial Junction

- There is no entry in the Alphabetic Index for “insertion of device in, cavoatrial junction”
- Body part key also has no entry for “cavoatrial junction” in the table.
Cavoatrial Junction

- The cavo-atrial junction is defined as the area between the right superior vena cava and the right atrium.
- The cavo-atrial junction has not yet reached the atrium.
Lysis of Adhesions

- Coders should not code adhesions and lysis thereof, based solely on mention of adhesions or lysis in an operative report. As is customary with other surgeries, it is irrelevant whether the adhesions or lysis of adhesions are included in the title of the operation. Determination as to whether the adhesions and the lysis are significant enough to code and report must be made by the surgeon.
Lysis of Adhesions

- Continue to look for the clinical significance of the adhesions. Documentation of clinical significance by the surgeon may include, but is not limited to, the following language: numerous adhesions requiring a long time to lyse, extensive adhesions involving tedious lysis, extensive lysis, etc.
- If uncertainty exists regarding clinical significance, then query the provider.
- See Coding Clinic First Quarter 2014 page 3 and Fourth Quarter 1990 page 18-19 for additional details.
Colectomy with End to End Anastomosis

• Per AHA Coding Clinic, Fourth Quarter 2014, page 42, When a right colectomy is performed with side-to-side functional end-to-end anastomosis, do not assign a code for the side-to-side functional end-to-end anastomosis. ICD-10-PCS Official Guidelines for Coding and Reporting, Section B3.1b, clarifies that procedural steps necessary to close the operative site, including anastomosis of a tubular body part, are not coded separately.

• This guideline would apply regardless of whether the procedure is an end-to-end or a side-to-side anastomosis.
Multiple Procedures

B3.2

During the same operative episode, multiple procedures are coded if:

a. The same root operation is performed on different body parts as defined by distinct values of the body part character.  
   Example: Diagnostic excision of liver and pancreas are coded separately.

b. The same root operation is repeated in multiple body parts, and those body parts are separate and distinct body parts classified to a single ICD-10-PCS body part value.  
   Example: Excision of the sartorius muscle and excision of the gracilis muscle are both included in the upper leg muscle body part value, and multiple procedures are coded.
Multiple Procedures

B3.2

During the same operative episode, multiple procedures are coded if:

c. Multiple root operations with distinct objectives are performed on the same body part.

*Example*: Destruction of sigmoid lesion and bypass of sigmoid colon are coded separately.

d. The intended root operation is attempted using one approach, but is converted to a different approach.

*Example*: Laparoscopic cholecystectomy converted to an open cholecystectomy is coded as percutaneous endoscopic Inspection and open Resection.
Total Hysterectomy

ICD-9

- For a total (open) hysterectomy, only 1 code is assigned.

ICD-10

- For a total (open) hysterectomy, 2 codes are assigned in ICD-10 (resection of uterus and resection of cervix)
- A total hysterectomy includes the removal of the uterus and cervix. Therefore, code both the resection of uterus and cervix. This is supported by the ICD-10-PCS Official Guidelines for Coding and Reporting, which state, “During the same operative episode, multiple procedures are coded if:
  - The same root operation is performed on different body parts as defined by distinct values of the body part character.”
  - Coding Clinic, Third Quarter 2013, page 28
ICD-10-PCS: Root Operation-Control

- The root term “control” specifically addresses postoperative bleeding.
- Examples of control procedures include postoperative ligation of bleeding arteries and drainage of postoperative hemorrhage.
- Control of other types of bleeding (i.e. intraoperative bleeding, are not coded using the Control root operation. See Coding Clinic, Third Quarter 2013, page 22
- Only three code tables are available for Control procedures: 0W3, 0X3, and 0Y3
ICD-10-PCS: Root Operation-Control

• If an attempt to stop post procedural bleeding is initially unsuccessful and to stop the bleeding requires performing any of the definitive root operations Bypass, Detachment, Excision, Extraction, Reposition, Replacement, or Resection, then that root operation is coded instead of Control.
  – Ex: Resection of spleen to stop post procedural coding is coded to resection instead of control

• *ICD-10 Guidelines-Section B3.7
Coding Example of When **Not** to Code Control

- History and Physical: patient presented with peritoneal hematoma.

- Operative Report documents hematoma of peritoneum was evacuated and drainage tube was placed.
  
  ✓ This was not a post procedural hematoma
  ✓ The objective of the procedure was to evacuate the clot
  ✓ When following the Alphabetic Index, “evacuation, hematoma” states to see Extirpation.
  ✓ Extirpation is defined as taking or cutting out solid matter (blood clot)
Coding Example of When to Code Control

Pre-Operative Diagnosis: Post-tonsillectomy bleeding
Post-Operative Diagnosis: Post-tonsillectomy bleeding
Operative Procedure: Operative Control of postoperative bleeding
Findings: Patient with an arterial bleeder from right tonsillar fossa.

Description of procedure: The patient was taken to the operating room and general anesthesia was administered. A Crowe-Davis mouth gag was placed, and clots were suctioned from the pharynx. An arterial bleeder was noted and was controlled with suction artery. The stomach was then suctioned and about 200-300 mL of blood was noted. The patient was awakened and extubated and transported to the recovery room in stable condition.
Coding Example of When to Code Control

RMC Internal Answer:

ICD-10-PCS code: 0W33XZZ (Control Bleeding in Oral Cavity and Throat, External Approach)

- The root operation control is coded because the bleeder is the result of a previous procedure. When cautery is used to stop post-op bleeding, control is the appropriate root operation. The tonsillar area is coded to the body part value 3. The approach is X (external)
The objective of the procedure is to make the joint immobile by fusing the articular parts.

Fusion root operations are only performed on joints with the objective of making them immobile. Therefore, the only code tables available for Fusion procedures are in the joint body systems—the upper joints (0RG) and the lower joints (0SG).

When building codes for spinal fusion, these tables are consulted based on the level of the spine involved in the fusion procedure. The number of body parts is based on the joint; however, and not the vertebrae.
Coding Tip

Guideline B3.10b states:

- “If multiple vertebral joints are fused, a separate procedure is coded for each vertebral joint that uses a different device and/or qualifier.”
  - For example, if L2-L3 are fused with a bone graft and L3-L4 are fused with an interbody fusion device, two codes are assigned, each identifying a different device used at each vertebral level.
  - If the anterior column of L4-L5 is fused from both a posterior approach and an anterior approach, two codes are assigned with different qualifiers for each spinal approach.
• The internal fixation/instrumentation (rods, plates, screws) are included in the fusion root operation, and no additional code is assigned. *Coding Clinic, 3rd Quarter 2014, page 30*

• Discectomy is almost always performed at the same time as spinal fusion. A discectomy can be coded separately.

• Review the documentation carefully to determine if it a total discectomy (resection) or partial discectomy (excision).
Question:
The patient presents for decompressive lumbar laminectomy. The surgeon performed an open complete decompressive laminectomy of L3-L4, as well as superior partial laminectomy of L5, and inferior partial laminectomy of L2. What is the appropriate root operation, “Excision” or “Release”? How is this surgery coded in ICD-10-PCS?

Answer:
Decompressive laminectomy is done to release pressure and free up the spinal nerve root. Therefore the appropriate root operation is “Release.” Assign the following ICD-10-PCS code:

01NB0ZZ Release lumbar nerve, open approach
Coding Clinic: Decompressive Laminectomy

*Coding Clinic*, Fourth Quarter 2013, page 116, advised the assignment of the root operation “Excision” for decompressive laminectomy procedures. This advice was based on the ICD-10-PCS’ Index entry “Laminectomy,” which instructs see Excision. The Editorial Advisory Board for Coding Clinic revisited this advice and determined that the root operation “Release” is more appropriate.
Contrast

- ICD-10-PCS requires coders to identify the type of contrast used for contrast based procedures.
- Current options include:
  - 0, high osmolar
  - 1, Low osmolar
  - Y, Other contrast
  - Z, none
- Contrast details can be found in medication administration records (MAR), Operative Report, and cardiac catheterization reports.
## Contrast Key

<table>
<thead>
<tr>
<th>Contrast Name</th>
<th>Osmolality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diatrizoate, Cysto-Conray II, Metrizoate, Ioxithalamte</td>
<td>High</td>
</tr>
<tr>
<td>Isovue, Omnipaque, Optiray, Oxilan, Ultravist, Xenetix, Iomeprol, Hexabrix, Iopentol</td>
<td>Low</td>
</tr>
<tr>
<td>Visapaque, Isovist</td>
<td>Other (Iso-osmolar)</td>
</tr>
</tbody>
</table>

CASE STUDIES
PTCA/Stent Case Study

Procedure: Primary PTCA and stent placement
Indications: Acute myocardial infarction

Procedure Description: Following left heart catheterization, a 6-French JR4 guiding catheter with side holes provided adequate support. The mid-right coronary artery occlusion was crossed with little difficulty using a 0/0014 BMW wire. Next the lesion was dilated using a 2 x 20 Maverick balloon. Next a 3 x 23 Vision stent was deployed in the mid-right coronary artery. A second 3.0 x 12 Vision stent was deployed proximal to the first stent with an intentional degree of overlap. Following successful primary PTCA and stent of the right coronary artery, there was a 0 percent residual stenosis with excellent antegrade flow. Perclose was utilized for vascular access site closure.
PTCA/Stent Case Study: Answers

ICD-10-CM: I21.3 (ST elevation myocardial infarction of unspecified site)

ICD-10-PCS: 02703DZ (Dilation of Coronary Artery, One Site with Intraluminal Device, Percutaneous Approach)

- Vision is a bare metal stent
- 2 stents but only one distinct site (mid right coronary artery)
- Coronary arteries are classified by number of distinct sites treated, rather than number of coronary arteries or anatomic name of coronary artery.

Multiple stents used to treat a single coronary artery lesion are identified with the device value intraluminal device or drug-eluting intraluminal device. When multiple stents classified to the same device value are used to treat a single coronary artery lesion, that information is not currently captured in the ICD-10-PCS code.
Ophthalmology Case Study

Pre-Op Diagnosis: Bilateral ptosis interfering with vision
Pre-Op Diagnosis: Same
Procedure: Bilateral levator resection
Anesthesia: IV
Operative Description: Under IV sedation, a 50/50 mixture of 2 percent Xylocaine with 1:100,000 epinephrine and Wydase, 0.5 percent Marcaine with epinephrine and sodium bicarbonate was injected into the area of the right and left upper lids via the skin surface. The patient was then prepped and draped in the usual sterile fashion. Attention was first directed to the upper eyelids, where a marking pen and caliper were used to mark the intended skin incision. Then 0.5 Cassidys and Brown-Adson forceps were used to delineate the skin to be excised. Curved Stevens’s scissors were used to excise the skin and orbicularis.
Operative Description: Hemostasis was maintained with monopolar cautery. A 4-0 Silk suture was placed in the lid margin, and the lid was placed on downward tension. The orbital septum was incised and opened for the full horizontal length of the eyelid. Then, the levator palpebrae superioris muscle was reflected from its insertion on the underlying tarsus and dissected from underlying Muller’s muscle. Multiple interrupted 5-0 Dexon sutures on a 01 needle were then positioned to fashion the tarsus and brought up the levator so that the appropriate height and contour of the eyelid were achieved. The excess levator was excised.
Operative Description: The wound was closed with a running 6-0 mild chromic suture. A combination corticosteroid and antibiotic ointment was placed in the patient’s eye and the wounds and ice packs were applied. Surgery was applied on the right and left eyes simultaneously to ensure symmetry. The patient left the operating room in good condition, fully awake.
Ophthalmology Case Study (Answers)

ICD-10-CM
H02.403 (Unspecified ptosis of bilateral eyelids)

ICD-10-PCS

08BP0ZZ (Excision of Left Upper Eyelid, Open Approach)
08BN0ZZ (Excision of Left Upper Eyelid, Open Approach)

**Explanation:** A medical indication is given for the procedure (interfering with vision); therefore, the root operation would not be Alteration. The root operation Excision is used to code the removal of a piece of levator muscle from each eyelid. The index directs to code the eyelid body part for the levator palpebrae superioris muscle. The body part values are P, Upper Eyelid, Left and N, Upper Eyelid, Right. The approach is open and no device or qualifier values are appropriate.
Traumatic Brain Injury Case Study

Chief Complaint: Car Crash

A xx year old female driver was involved in a car crash on I-Superfast. Patient collided with a SUV. Patient was talking on cellular phone with mother prior to accident. Patient brought to ER in a coma where she is diagnosed with TBI with loss of consciousness of one hour. Glasgow coma scale was 5 on arrival in ED.
Procedure: The patient underwent endotracheal intubation and subsequently placed on mechanical ventilation

Discharge Diagnosis: Traumatic brain injury. Patient was transferred to trauma center for further care.
Traumatic Brain Injury Case Study: Answers

ICD-10-CM
S06.9X3A (Unspecified intracranial injury with LOC of 1-5 hours 59 min, initial)
R40.243 (Glasgow coma scale score 3-8)
V43.51XA (Car driver injured in collision with sport utility vehicle in traffic accident, initial encounter)
Y93.C2 (Activity, hand held interactive electronic device)
Y92.411 (Interstate highway as the place of occurrence of the external cause)
Traumatic Brain Injury Case Study: Answers

ICD-10-PCS

0BH17EZ (Insertion of Endotracheal Airway into Trachea, Via Natural or Artificial Opening)

5A1935Z (Respiratory Ventilation, Less than 24 Consecutive Hours)
Anemia Case Study: Question

I have a patient admitted for chronic blood loss anemia due to a bleeding mass from esophageal cancer. Nothing can be done for the cancer. Admitted due to the anemia for transfusions. The guideline from the handbook says D63.0 would be secondary to the anemia. In my case I coded D50.0 for chronic blood loss anemia. So would the guideline still apply?
Coding Guideline

Admission for Complications Associated with a Malignant Neoplasm

Patients with malignant neoplasms often develop complications due to either the malignancy itself or the therapy that they have received. When admission is primarily for treatment of the complication, the complication is coded first, followed by the appropriate code(s) for the neoplasm.

The exception to this guideline is anemia. When the admission/encounter is for management of an anemia associated with the malignancy, and the treatment is only for anemia, the appropriate code for the malignancy is sequenced as the principal or first-listed diagnosis, followed by code D63.0, Anemia in neoplastic disease. When the admission/encounter is for management of an anemia associated with an adverse effect of the administration of chemotherapy or immunotherapy, and the only treatment is for the anemia, the anemia code is sequenced first, followed by the appropriate codes for the neoplasm and the adverse effect (T45.1x5-). For example:
Anemia Case Study: Answer

Anemia exists because of the malignancy, therefore the cancer would be the principal diagnosis followed by the D50.0 and the D63.0 as secondary diagnoses. As per OCG.
Patient had an open annuloplasty of the mitral valve with a synthetic substitute without a leaflet excision and also 2 Gore patches sutured in other 2 different parts of the mitral valve (without any excision). When coding in 3M you will get the same code – 02UG0JZ for the annuloplasty as well as for the repair of heart valve with a synthetic patch. Wanting to reflect both parts of the procedure am I allowed to use code 02UG0JZ for annuloplasty and code 02QG0ZZ for the other repair of the valve? Code 02QG0ZZ will not influence the DRG.
Annuloplasty of the Mitral Valve Case Study: Answer

Both areas of mitral valve have a patch therefore they both go to supplement. Repair would not be appropriate. See index of PCS Code book for definition of repair as root operation.

Per the ICD 10 PCS coding handbook: The root operation “Repair” represents a broad range of procedures for restoring, to the extent possible, a body part to its normal anatomical structure and function. This root operation is only used when the procedure performed does not meet the definition of one of the other root operations. Examples of “Repair” include herniorrhaphy and suturing of laceration.
Adult ADD Case Study: Question

How do you code adult ADD? 3M rejects code F98.8 for age incompatibility in an adult, is there an alternative?
Adult ADD Case Study: Answer

RMC Internal Answer:
RMC will be sending to ICD 10 Ombudsman and Coding Clinic for official guidance.

Defer to individual facility policy and payer instructions
Adult ADD Case Study: Answer

RMC Internal Answer:
RMC will be sending to ICD 10 Ombudsman and Coding Clinic for official guidance.

Trainers recommend coding R41.840- Attention and concentration deficit until official guidance from above resources.
Update From Ombudsman

Thank you for expressing concern with the ICD-10 Medicare Code Editor (MCE) Age Conflict- Pediatric Diagnosis code edit for ICD-10-CM code F98.8 (Other specified behavioral and emotional disorders with onset usually occurring in childhood and adolescence). We are addressing this issue as part of our annual MCE updates for the FY 2017 inpatient PPS proposed rule. This proposed rule will be published in April/May 2016. Please contact your local MAC to make them aware of any claims that have been denied or rejected in error. If you need help determining contact information for the MAC serving your jurisdiction, please refer to the following link: https://www.cms.gov/Medicare/Coding/ICD10/ICD-10-Provider-Contact-Table.pdf.
Tumor of Cecum Case Study: Question

This patient admitted with previously biopsied low grade tumor of cecum and underwent a resection. Path showed well-differentiated neuroendocrine CA with LN met. I submitted a query and the attending documented “Well differentiated neuroendocrine (Carcinoid) tumor of cecum.” Per Alpha index, we have to choose between benign and malignant carcinoid tumor. From previous facilities I’ve worked at, they recommended to assign the malignant unless they specifically document benign tumor.

Sent Query for addition of the mets site.
Query:
Dear Dr. XXX,
Carcinoid tumor of cecum is documented in the discharge summary. Path report includes the final diagnosis of well-differentiated neuroendocrine carcinoma with lymph node metastasis, pT3 N1.
As low grade tumor and well-differentiated neuroendocrine carcinoma are classified to different diagnosis codes, we'd appreciate if you could clarify and document the final diagnosis after study (with metastatic site, if applicable) to the discharge summary as addendum.
Tumor of Cecum Case Study: Question

(PROVIDER REPLY:) The final diagnosis has been amended to "Well differentiated neuroendocrine(carcinoid) tumor of the cecum" which accurately reflects the pathologic diagnosis.
Tumor of Cecum Case Study: Answer

Typically benign tumors do not metastasize. The pathology report indicates that there was lymph node metastasis, thereby a malignant tumor, however the pathological findings have not been confirmed by the attending physician. It would be inappropriate to assume malignant until the provider has clarified.

**It is important to query with terms that are easily indexable in the ICD10 code book. Trainers suggest requery to the provider with term choices such as "benign“, "malignant“, “unable to determine” for a clear response from the attending physician.
Query:

(Part 1) Dear provider, Please document in summary addendum if the carcinoid tumor is 1. Benign, 2. Malignant, 3. Other, 4. Undetermined

(Part 2) Please document in summary addendum if you agree with the pathologic diagnosis of lymph node metastasis, as coders are unable to code from the pathology report.
Tumor of Cecum Case Study: Provider Update

Provider replied to query with "malignant carcinoid tumor"
Mismatched Body Part in Screening Colonoscopy Case Study: Question

Screening colonoscopy, polyp was found at the hepatic flexure. In ICD-10 hepatic flexure codes to transverse colon (D12.3), but according to the PCS body part key hepatic flexure codes to the ascending colon.

So the problem on this account is that we have a dx of transverse polyp not matching the procedure of excision of ascending colon. What to do, what to do??
Mismatched Body Part in Screening Colonoscopy Case Study: Answer

Recommendation: Code as is, sometimes the codes do not match. However the coder needs to verify that site of excision and site of polyp are indeed accurate.
Lysis of Adhesions Case Study: Question

I was wondering how to code lysis of adhesions of the heart. I came up with 02NN0ZZ. (this is pericardium, not sure if I am using the correct Body Part) The surgeon says “extremely dense substernal adhesions were divided with the scissors and electrocautery. Adhesions were unusually severe all over the heart. They were divided.”
Lysis of Adhesions Case Study: Answer

Recommend a query to decipher which part of the heart is being freed (i.e., Right or left atrium, right or left ventricle, pericardium or other internal structure)
What and How

Think about **what** your coding and how you’re coding.

- Apply guideline for secondary dx
  - clinical evaluation; or
  - therapeutic treatment; or
  - diagnostic procedures; or
  - extended length of hospital stay; or
  - increased nursing care and/or monitoring.
Tips

• Review coding AND documentation quality
• Feedback to CDI/Providers AND Coders
• Educate! Discuss! Educate!
• Resource for staff questions
"...and that is why we lift on three..."
Resources

AHA Coding Clinic
ICD 10 CM and PCS Coding Handbook 2016
ICD-10-PCS: An Applied Approach, 2015, Kuehn, Lynn
Ref 1: http://www.healthcareitnews.com/sites/default/files/companion_images/icd10_2.png
Ref 2: http://www.memes.com/meme/717099
Ref 4: http://legacy.owensboro.kctcs.edu/gcaplan/anat/images/Image256.gif
Ref 5: http://englishwithatwist.com/wp-content/uploads/2013/05/Blog-communication-cartoon.jpg
Ref 6: https://www.pinterest.com/pin/440297301041910386/
Thank you!!!!!!
Email: stacy@rmcinc.org

I-10 OVERLOAD
Is there a code for that?