Learning Objectives

- At the completion of this educational activity, the learner will be able to:
  - Provide an overview on structure of ICD-10-CM/PCS coding conventions, guidelines, and official advice essential to understanding Coding Clinic guidance
  - Outline the history, authority, and utility of Coding Clinic for ICD-10-CM/PCS in promoting documentation and coding compliance
  - Explore recent Coding Clinic advice and concepts affecting CDI practice
  - Develop strategies that engage Coding Clinic to help us solve challenges with ICD-10
The AHA Central Office
Origins and Goals

- Created through a written Memorandum of Understanding between the American Hospital Association (AHA) and the National Center for Health Statistics (NCHS) in 1963 to:
  - Serve as the U.S. clearinghouse for issues related to the use of ICD-9-CM and ICD-10
  - Work with NCHS, the Centers for Medicare & Medicaid Services (CMS), and AHIMA (American Health Information Management Association)—known as the Cooperating Parties—to maintain the integrity of the classification system
  - Recommend revisions and modifications to the current and future revisions of the International Classification of Diseases
  - Develop educational material and programs on ICD-10-CM/PCS
- Whereas the ICD-10-CM/PCS transaction sets (supplemented by the Guidelines) are the Constitution, Coding Clinic serves as the Supreme Court in interpreting ICD-9-CM or ICD-10-CM/PCS and their guidelines. Its advice is official.

The AHA Central Office Staff

Nelly Leon-Chisen, RHIA
- Director, Coding and Classification, & Executive Editor for AHA Coding Clinic for ICD-10-CM/PCS and AHA Coding Clinic for HCPCS
- Managing editor
  - Anita Rapier, RHIT, CCS
- Senior coding consultants
  - Gretchen Young Charles, RHIA
  - Benjamin D. Olsen, RHIT, CCS, CCS-P
  - Denise M. Harper, RHIA
- Medical advisors (CMS)
  - Daniel I. Dovin, MD
  - Songhao Barth, MD, FACMG
  - Karen Nolan, MD
- Coding consultants
  - Melina Zebed-Materneh, RHIA
  - Kathy White, RHIA
  - Cherrase Ruffin, RHIT
  - Diane Komer, RHIT
  - Patricia D. Jones, RHIT
The AHA Central Office

Editorial Advisory Board (EAB)

- The EAB for Coding Clinic for ICD-10-CM/PCS was developed to ensure that the needs of users of these classification systems are addressed
  - Assists hospitals/networks in collecting and reporting standardized quality data by:
    - Advocating to ensure data used by integrated information systems and federal programs is based upon clearly defined and uniform standards
    - Serving as the authoritative source of coding/classification information
  - Meets quarterly for 2–3 days (or as needed) to address issues brought to them by Central Office staff
    - Reactive to Central Office issues, not proactive
    - Meetings are NOT open to the public
    - EAB members are sworn to secrecy on their deliberations

The AHA Central Office

EAB Membership – Voluntary

- Cooperating Parties
  - Donna Pickett, RHIA – CDC (responsible for diagnoses)
  - Patricia Brooks, RHIA – CMS (responsible for procedures)
  - Nelly Leon-Chisen – AHA – Editor of Coding Clinic
  - Sue Bowman, RHIA – AHIMA
- Dona Ganzer – Chairman
  - Retired AHA executive
- Coders from the provider community, such as
  - Montefiore Medical Center, Community Health Systems, SSM Health

- Providers (practicing MDs) representing
  - American Medical Association
  - American College of Physicians
  - American College of Surgeons
  - American Academy of Pediatrics
  - Veterans Administration Health Care System

- Invited guests or Cooperating Party employees/contractors
  - 3M Health Information Systems
  - ICD-10-PCS contracting agent
  - Coding Clinic staff
  - CMS Medical Advisors

Consultants are prohibited from membership, even if nominated

The AHA Central Office

Coding Clinic for ICD-10-CM/PCS

- Publishes Coding Clinic for ICD-10-CM and ICD-10-PCS
  - 2012–present ICD-10-CM/PCS

- Deemed as official advice by the ICD-10-CM/PCS Cooperating Parties
  - Other publications, while perhaps written by the Central Office or other members of the Cooperating Parties, are not official

- Changes in the ICD-9-CM (now ICD-10-CM/PCS) classification supersede previously published Coding Clinic advice
  - Coding Clinic (CC), First Quarter 2011, p. 19

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Use of Coding Clinic for ICD-9-CM With ICD-10-CM/PCS

- 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-9-CM and ICD-10-PCS to replace it, the advice would stand

Coding Clinic ICD-10, Fourth Quarter 2015, pp. 20–21

Use of Coding Clinic for ICD-9-CM With ICD-10-CM/PCS

- Previously published ICD-9-CM advice that is still relevant and applicable to ICD-10 will continue to be re-published in Coding Clinic for ICD-10-CM/PCS
  - As with the application of any of the coding advice published in Coding Clinic, the information needs to be reviewed carefully for similarities and differences on a case-by-case basis
- In order to simplify the learning process, when the Cooperating Parties developed the ICD-10-CM guidelines, 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
  - If a particular guideline has remained exactly the same in both coding systems, and Coding Clinic for ICD-9-CM has published an example of the application of that guideline, it’s more than likely that the interpretation would be similar

Use of Coding Clinic for ICD-9-CM With ICD-10-CM/PCS

- Care must be exercised as the codes may have changed. Such change could be related to new codes, new combination codes, code revisions, a change in nonessential modifiers, or any other instructional note. This is particularly true as ICD-10-CM has many new combination codes that were not available in ICD-9-CM.
  - For example, previous Coding Clinic for ICD-9-CM advice has indicated that hypoxia is not inherent in chronic obstructive pulmonary disease (COPD) and it could be separately coded. Coders should not assume this advice inevitably applies to ICD-10-CM. [???]
  - The correct approach when coding with ICD-10-CM is to review the Index entries for COPD, and determine whether or not there is a combination code for COPD with hypoxia, verify the code in the Tabular List, and review any instructional notes. The coder should then determine whether to code the hypoxia separately—and not automatically assume that a separate code should be assigned.
Hypoxia With COPD

It appears OK to add hypoxemia if documented

Send Your Own Questions to Coding Clinic Advisor

Anyone can send in questions and do it online

- [http://www.codingclinicadvisor.com](http://www.codingclinicadvisor.com)
- Always best to submit a de-identified medical record
- Responses sent by U.S. mail (may take a while)

It's FREE!

Obtaining Coding Clinic Advice Subscribing

<table>
<thead>
<tr>
<th>Annual Subscription</th>
<th>Unlimited Subscription</th>
<th>Student Subscriptions</th>
</tr>
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<tr>
<td>Benefits</td>
<td>Benefits</td>
<td>Benefits</td>
</tr>
<tr>
<td>Easy Access</td>
<td>Online accessibility</td>
<td>Note: AHIMA and AHA rates not available on website</td>
</tr>
<tr>
<td>Downloadable PDF</td>
<td>Cost Effective</td>
<td>Call them to get discounts – 800-621-6903</td>
</tr>
<tr>
<td>Printables</td>
<td>Available for Quarter or Semester</td>
<td></td>
</tr>
</tbody>
</table>

$375 – General public
$294 – AHIMA member
$245 – AHA member

$1,300 – initial year

No pricing yet
Diagnoses
ICD-10-CM Hierarchy

1. ICD-10-CM Index to Diseases
   - The term must be looked up here first
2. ICD-10-CM Table of Diseases
   - Offers additional instructions, such as “code first,” “code in addition,” “in diseases classified elsewhere,” “Excludes1,” “Excludes2,” and others
3. ICD-10-CM Official Guidelines for Coding and Reporting
   - May add or subtract codes or influence sequencing
4. Advice from Coding Clinic for ICD-10-CM/PCS
   - May add or subtract codes or influence sequencing
   - Occasionally can overrule the Index, Table, and Guidelines
5. Court opinions or other payer-specific regulations

How to Look Up a Diagnosis Code
Chronic Kidney Disease

Essential to use both the Index (first) and then the Table when looking up a code!
Acute respiratory distress or insufficiency and “adult” respiratory distress syndrome shared the same code in ICD-9-CM
• A MS-DRG “CC” for patients admitted with asthma or decompensated heart failure without acute respiratory failure

Acute respiratory distress syndrome (ARDS), previously known as respiratory distress syndrome (RDS), acute lung injury, adult respiratory distress syndrome, or shock lung
– Is a severe, life-threatening medical condition characterized by widespread inflammation in the lungs
– Is a disease of the microscopic air sacs of the lungs (alveoli) that leads to decreased exchange of oxygen and carbon dioxide (gas exchange)
– Is associated with several pathologic changes: The release of inflammatory chemicals, breakdown of the cell lining the lung blood vessels, surfactant loss leading to increased surface tension in the lung, fluid accumulation in the lung, and excessive scarring

If the patient has acute respiratory distress but does not have ARDS, should J80, acute respiratory distress syndrome, be assigned?
Hypoxemia & Hypercapnia
Respiratory Insufficiency/Failure in ICD-10-CM

<table>
<thead>
<tr>
<th>Entity</th>
<th>MS-DRG</th>
<th>APR – SOI</th>
<th>APR – ROM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypoxemia</td>
<td>No CC</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Hypercapnia</td>
<td>No CC</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Respiratory insufficiency or distress</td>
<td>No CC</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Acute respiratory insufficiency</td>
<td>No longer a CC in MS-DRGs</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Acute respiratory distress</td>
<td>A CC if considered to be ARDS</td>
<td>SOI 2 if considered to be ARDS</td>
<td>ROM 3 if considered to be ARDS</td>
</tr>
<tr>
<td>Acute resp. failure</td>
<td>MCC</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Chronic resp. failure</td>
<td>CC</td>
<td>3</td>
<td>2</td>
</tr>
</tbody>
</table>

Acute respiratory insufficiency and distress were CCs in ICD-9-CM

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Answer Pending From Coding Clinic Advisor

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ICD-10-CM Index
“With” vs. “Due to” vs. “In”

- ICD-10-CM Guidelines
  - The word “with” should be interpreted to mean “associated with” or “due to” when it appears in a code title, the Alphabetic Index, or an instructional note in the Tabular List
  - “Due to” means “due to” – must be explicitly linked as a cause and effect
  - “In” also means “Due to”
- **ICD-10-CM Guidelines**  
  - The word “with” should be interpreted to mean “associated with” or “due to” when it appears in a code title, the Alphabetic Index, or an instructional note in the Tabular List  
  - “Due to” means “due to” – must be explicitly linked as a cause and effect  
  - “In” also means “Due to”  

**Diabetes “With” Conditions**  
- According to the ICD-10-CM *Official Guidelines for Coding and Reporting*, 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, and this is how it’s meant to be interpreted when assigning codes for diabetes with associated manifestations and/or conditions  
  - The classification assumes a cause-and-effect relationship between diabetes and certain diseases of the kidneys, nerves, and circulatory system  
  - Assumed cause-and-effect relationships in the classification are not necessarily the same in ICD-9-CM and ICD-10-CM  

*Coding Clinic ICD-10, First Quarter 2016*, p. 11  

**ICD-9-CM vs. ICD-10-CM Diabetes**  
- Note that the list of conditions “with” diabetes is longer in ICD-10-CM  
- Note osteomyelitis is not on the list in ICD-10-CM  
- Note foot ulcer, nephropathy, CKD, and neuropathy are on the list
Diabetes “With” Osteomyelitis
Coding Clinic, First Quarter 2016, p. 13

• **Question:** A woman, who has had type 1 diabetes for over 40 years, developed chronic osteomyelitis of the right heel and presents to the infectious disease clinic for follow-up.
  – The provider also notes, “Chronic renal impairment (creatinine 2.9) due to diabetes.”
  – Does ICD-10-CM assume a relationship between diabetes and osteomyelitis when both conditions are present?
• **Answer:** No, 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.
  – This information is consistent with that previously published in Coding Clinic, Fourth Quarter 2013, p. 114.

Diabetes “With” ESRD, Neuropathy, Foot Ulcer
Coding Clinic, First Quarter 2016, pp. 12–13

• **Question:** The provider documents, “Diabetic foot ulcer with skin breakdown, positive for Methicillin resistant Staphylococcus aureus (MRSA) infection.”
  – The patient also had been diagnosed with polyneuropathy, end-stage renal disease (ESRD), on hemodialysis maintenance.
  – Does the ICD-10-CM assume a cause-and-effect relationship between the diabetes mellitus, the foot ulcer, polyneuropathy, and ESRD? How should this case be coded?
• **Answer:** ICD-10-CM assumes a causal relationship between the diabetes mellitus and the foot ulcer, the polyneuropathy, as well as the chronic kidney disease.
  – Note: Though ESRD is documented, it falls under the category of chronic kidney disease in the ICD-10-CM Table.

Diabetes “With” Conditions

• **However, if the physician documentation specifies diabetes mellitus is not the underlying cause of the other condition, the condition should not be coded as a diabetic complication**
  – When the coder is unable to determine whether a condition is related to diabetes mellitus, or the ICD-10-CM classification does not provide coding instruction, it is appropriate to query the physician for clarification so that the appropriate codes may be reported.

Coding Clinic ICD-10, First Quarter 2016, p. 11–12
Diabetes “With” Conditions

- "It is not required that two conditions be listed together in the health record.
  - However, the provider needs to document the linkage, except for situations where the classification assumes an association (e.g., hypertension with chronic kidney involvement).
- When the provider establishes a linkage or relationship between the two conditions, they should be coded as such.
  - However, the entire record should be reviewed to determine whether a relationship between the two conditions exists.
    - The fact that a patient has two conditions that commonly occur together does not necessarily mean they are related.
    - A different cause may be documented by the provider.
- If it is not clear whether or not two conditions are related, query the provider.”

Coding Clinic, Third Quarter 2012, p. 3

Ulcers “With” Diabetes

Diabetes, diabetic (mellitus) (sugar) E11.9
- with
  - foot ulcer E11.621
  - skin complication NEC E11.628
  - skin ulcer NEC E11.622
- Note that in ICD-10-CM, any skin ulcer occurring in diabetes is linked to diabetes unless the physician explicitly states that the ulcer is due to another cause (e.g., pressure ulcer, venous insufficiency).

Clinical clue
It is important to recognize that not all ulcers in diabetic patients are diabetic ulcers.
- Diabetic ulcers of the foot generally start on the toes and move upward.
- Diabetic ulcers do not usually start on the heel. Ulcers of the heel are almost always decubiti.

Coding Clinic, First Quarter 2004, pp. 14–15

Ulcers “With” Diabetes
Non-Pressure vs. Pressure DRGs

PDx – heel ulcer with exposed fat in a diabetic
MS-DRG affected

PDx – pressure ulcer with necrosis of subQ tissue
APR-DRG not affected

Note: Stage 3 pressure ulcers are defined by the ICD-10-CM table as “full thickness skin loss involving damage or necrosis of subcutaneous tissue”
**Excludes1 and Excludes2 Notes**

**ICD-10-CM Official Guidelines**

- **Excludes1**
  - A Excludes1 note is a pure excludes note. It means "NOT CODED HERE!"
  - An Excludes1 note indicates that the code excluded should never be used at the same time as the code above the Excludes1 note.
  - An Excludes1 is used when two conditions cannot occur together, such as a congenital form versus an acquired form of the same condition.

- **Excludes2**
  - A Excludes2 note means "Not included here."
  - An Excludes2 note indicates that the condition excluded is not part of the condition represented by the code, but a patient may have both conditions at the same time.
  - When an Excludes2 note appears under a code, it is acceptable to use both the code and the excluded code together, when appropriate.

---

**Respiratory Distress Syndrome and Respiratory Failure of Newborn**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>P22.0</td>
<td>Respiratory distress syndrome of newborn Cardiorespiratory distress syndrome of newborn NOS (P28.6)</td>
</tr>
<tr>
<td>P22.1</td>
<td>Transient tachypnea of newborn Idiopathic tachypnea of newborn Respiratory distress syndrome, type 1 Respiratory distress syndrome, type II Wet lung syndrome</td>
</tr>
<tr>
<td>P22.8</td>
<td>Other respiratory distress of newborn P22.9</td>
</tr>
</tbody>
</table>

---

**Excludes1 Note Caveat**

**Coding Clinic, Fourth Quarter 2015**

- There are circumstances that have been identified where some conditions included in Excludes1 notes should be allowed to both be coded, and thus might be more appropriate for an Excludes2 note
  - However, due to the partial code freeze, no changes to Excludes notes or revisions to the official coding guidelines can be made until October 1, 2016
  - This new guidance concerning Excludes1 notes is intended to allow conditions to be reported together when appropriate even though they may currently be subject to an Excludes1 note

**Excludes1 Note Caveat**

*Coding Clinic, Fourth Quarter 2015*

- **Question:** We have received several questions regarding the interpretation of Excludes1 notes in ICD-10-CM when the conditions are unrelated to one another. How should this be handled?
- **Answer:** If the two conditions are not related to one another, it is permissible to report both codes despite the presence of an Excludes1 note.
  - For example, the Excludes1 note at code range R40–R46 states that symptoms and signs constituting part of a pattern of mental disorder (F01–F99) cannot be assigned with the R40–R46 codes.
  - However, if dizziness (R42) is not a component of the mental health condition (e.g., dizziness is unrelated to bipolar disorder), then separate codes may be assigned for both dizziness and the mental health condition.
  - In another example, code range I60–I69 (cerebrovascular disease) has an Excludes1 note for traumatic intracranial hemorrhage (S06–). Codes in I60–I69 should not be used for a diagnosis of traumatic intracranial hemorrhage.
  - However, if the patient has both a current traumatic intracranial hemorrhage and sequelae from a previous stroke, then it would be appropriate to assign both a code from S06 and I69.


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**Excludes1 Note**

*Neutropenia and Pancytopenia*

---

**Neutropenia With Pancytopenia**

*Coding Clinic, Fourth Quarter 2014, pp. 22–23*

- **Question:** A patient with anemia and thrombocytopenia is admitted with fever and neutropenia. The provider documented that the neutropenia and anemia are secondary to chemotherapy for medulloblastoma with spinal metastasis. Since pancytopenia includes anemia, neutropenia, and thrombocytopenia, is it appropriate to assign a code for pancytopenia when the neutropenia is secondary to chemotherapy?
- **Answer:** Assign code D70.1, Agranulocytosis secondary to cancer chemotherapy, as the principal diagnosis. Codes R50.81, Fever with conditions classified elsewhere, T45.1, Toxic effect of antineoplastic and immunosuppressive drug, initial encounter, D64.81, Anemia due to antineoplastic chemotherapy, and D69.59, Other secondary thrombocytopenia, should be assigned as additional diagnoses.
- **Patients may present with both pancytopenia and neutropenia with fever. They are clinically different processes.** The pancytopenia code alone does not convey the complete clinical picture. However, the Excludes1 note at category D61, Other aplastic anemias and other bone marrow failure syndromes, prohibits assigning code D70.1 along with a pancytopenia code in this category. The National Center for Health Statistics (NCHS) has agreed to address the issue of the Excludes1 at category D61 at a future ICD-10-CM Coordination and Maintenance Committee (C&M) meeting.

Note: The DRG impact of changing to an Excludes2 note is minimal.
Take-Home Lesson
Excludes1 Waiver

• Consider developing written policies of what common “Excludes1 conditions” are not “related to each other”
  – Clear-cut examples are those published by Coding Clinic and the CDC (e.g., neutropenia and pancytopenia; mental disorders with R40-R46 codes)
  – A controversial example may be acute respiratory failure with respiratory distress syndrome
  • Many maintain respiratory failure is related; some do not
    – Worth getting an opinion from your neonatologists
    – Perhaps Coding Clinic Advisor would be of help
• Essential to have in place for audit defense

Coding Clinic’s Impact on Auditors
Sepsis-3

2015 Payer-Specific Regulations
RADV and RACs

• CMS authorizes outside entities to deny ICD-9-CM or ICD-10 code assignment, even based on provider assignment. These include:
  – Recovery Audit Contractors (RAC) – Inpatient DRGs
  – Risk Adjustment Data Validation (RADV) – Outpatient HCCs

  Sample criteria for RADV

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**Question:** Can you help with coding disputes with payers when they don’t follow Coding Clinic (CC) advice or the Official Guidelines for Coding and Reporting?

**Answer:** Traditionally CC does not address coding for reimbursement. CC’s goal is to provide advice according to the most accurate and correct coding consistent with ICD-10-CM and ICD-10-PCS principles. The official guidelines are part of the HIPAA code set standards. There are a variety of payment policies that may impact coding. Some payment policies may contradict each other or may be inconsistent with coding rules/conventions. Therefore, it is not possible to write coding guidelines that are consistent with all existing payer guidelines.

---

**The following advice is provided to help providers resolve coding disputes with payers:**

1. First, determine whether it is really a coding dispute and not a coverage or payment issue. Therefore, always contact the payer for clarification if the reason for the denial is unclear.
2. If a payer really does have a policy that clearly conflicts with official coding rules or guidelines, every effort should be made to resolve the issue with the payer. Provide applicable coding rule/guideline to payer.
3. If the payer refuses to change its policy, obtain the payer requirements in writing. If the payer refuses to provide its policy in writing, document all discussions with the payer, including dates and the names of individuals involved in the discussion. Confirm the existence of the policy with the payer’s supervisory personnel.
4. Keep a permanent file of the documentation obtained regarding payer coding policies. It may come in handy in the event of an audit.

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**Sepsis-2 vs. Sepsis-3 Clinical Validity**

- **Coding Clinic’s take on sepsis validity**
  - **CC, 1st Quarter 2016 − Q.** Is it appropriate to assign a code for “resolving sepsis”? Does it matter if the patient is treated with antibiotics?
  
  **A.** The patient is no longer actively septic, so instead code the underlying infection that triggered the sepsis.
  - **CC, 2nd Quarter, 2012, p. 15 − The Editorial Advisory Board (EAB) for Coding Clinic has become aware of a pattern of documentation problems concerning patients transferred to the LTC with a diagnosis of sepsis. Physician advisers reviewing these cases did not agree that these patients were truly septic since they had no clinical indicators.**
  - **In both of these opinions, Coding Clinic states, “If the documentation is unclear as to whether the patient is still septic, query the provider for clarification.”**
2001 Definition of SIRS/Sepsis

Sepsis-2

- INFECTION
- SEPSIS
- SEVERE SEPSIS
- SEPTIC SHOCK
- PANCREATITIS
- SIRS or Organ D/O
- BURNS
- TRAUMA
- OTHER

Bone et al. Chest 1992;101:1644

SIRS or Organ D/O INFECTION PANCREATITIS

2001 Definition of SIRS/Sepsis

Sepsis-2

- INFECTION
- SEPSIS
- SEVERE SEPSIS
- SEPTIC SHOCK
- PANCREATITIS
- SIRS or Organ D/O
- BURNS
- TRAUMA
- OTHER

Bone et al. Chest 1992;101:1644

Sepsis Adult Redefinition (Sepsis-3)
February 22, 2016

Announced at the SCCM meeting in Orlando on February 22, 2016
Published in JAMA on February 23, 2016
http://www.tinyurl.com/2016sepsis

Sepsis Adult Redefinition Requirement for Organ Dysfunction

- Sepsis is now defined as a “life-threatening organ dysfunction due to a dysregulated host response to infection”
  - In this new definition the concept of the non-homeostatic host response to infection is strongly stressed while the SIRS criteria have been removed
  - The inflammatory response accompanying infection (pyrexia, neutrophilia, etc.) often represents an appropriate host response to any infection, and this may not necessarily be life-threatening
Sepsis-3 Adult Redefinition
Organ Dysfunction – SOFA Scores

- The key element of sepsis-induced organ dysfunction is defined by "an acute change in total SOFA score ≥ 2 points consequent to infection, reflecting an overall mortality rate of approximately 10%"
  - The baseline Sepsis-related Organ Failure Assessment (SOFA) score may be taken as 0 unless the patient is known to have previous comorbidity (e.g., head injury, chronic kidney disease, etc.)
  - In light of this, the current definition of "severe sepsis" becomes obsolete, as does the term

Still need diagnoses to support these clinical indicators
2005 Pediatric Sepsis Definition
SIRS – Sepsis (Similar to Sepsis-1 and 2)

Table 3. Definitions of systemic inflammatory response syndrome (SIRS), sepsis, severe sepsis, and septic shock

* SIRS is the presence of at least two of the following four criteria, one of which must be abnormal temperature or leukocyte count.
* The criteria do not have to be present at the same time; sepsis is defined as the presence of at least one SIRS criterion in the absence of surgical infection.

“SIRS” criteria in pediatrics different than adults
Sepsis-3 does not apply to children
SOFA does not apply to children


2005 Pediatric Sepsis
SIRS Components

Table 4. Age-specific Vital signs and laboratory parameters lower limits for heart rate, temperature count, and specific blood present in the 3rd and 4th parameters for the SIRS criteria in pediatrics according to the 3rd and 4th parameters for the SIRS criteria in pediatrics.

“SIRS” criteria in pediatrics different than adults
Sepsis-3 does not apply to children
SOFA does not apply to children


2005 Pediatric Sepsis
Organ Dysfunctions

Table 5. Organ dysfunction criteria


Look for new pediatric sepsis criteria sometime in the next year or so.
Sepsis-2 vs. Sepsis-3
Sepsis Validity

While Sepsis-3 requires acute organ dysfunction to define sepsis, a provider must document "severe sepsis" or link the organ dysfunction to sepsis to obtain a code for severe sepsis.
Heart Failure w/Preserved EF (HFpEF)
Heart Failure w/Reduced EF (HFrEF)

- **Question:** If a physician documents heart failure with preserved ejection fraction (HFpEF), or heart failure with reduced ejection fraction (HFrEF), can the coder assume the physician means “diastolic heart failure” or “systolic heart failure,” respectively, and apply the proper ICD-9-CM code based on the documented clinical circumstances?
  - **Answer:** No, the coder cannot assume either diastolic or systolic failure or a combination of both, based on these newer terms. Therefore, query the provider to clarify whether the patient has diastolic or systolic heart failure.

_Coding Clinic ICD-10, First Quarter 2014, p. 25_

Heart Failure w/Preserved EF (HFpEF)
Heart Failure w/Reduced EF (HFrEF)

- Based on additional information received from the American College of Cardiology (ACC), the Editorial Advisory Board for Coding Clinic for ICD-10-CM/PCS has reconsidered previously published advice about coding heart failure with preserved ejection fraction (HFpEF) and heart failure with reduced ejection fraction (HFrEF)
  - HFpEF may also be referred to as heart failure with preserved systolic function, and this condition may also be referred to as diastolic heart failure
  - HFrEF may also be called heart failure with low ejection fraction, or heart failure with reduced systolic function, or other similar terms meaning systolic heart failure

_Coding Clinic ICD-10, First Quarter 2016, p. 25_

Heart Failure w/Preserved EF (HFpEF)
Heart Failure w/Reduced EF (HFrEF)

- These terms HFpEF and HFrEF are more contemporary terms that are being more frequently used, and can be further described as acute or chronic
- Therefore, when the provider has documented HFpEF, HFrEF, or other similar terms noted above, the coder may interpret these as “diastolic heart failure” or “systolic heart failure,” respectively, or a combination of both if indicated, and assign the appropriate ICD-10-CM codes

_Coding Clinic ICD-10, First Quarter 2016, p. 25_

Kennedy note: The provider must still state “acute,” “decompensated,” or “acute on chronic” for a coder to use the higher-weighted codes
Adverse Effects of Coumadin

Coumadin Coagulopathy – ICD-9-CM
Not Allowed

• Question: A patient is admitted with hemoptysis and blood in stool. The physician states that the hemoptysis and blood in stool were due to coagulopathy related to the patient’s recent usage of Coumadin. What is the appropriate diagnosis code assignment(s) for this case?

• Answer: Assign code 786.3, Hemoptysis, or code 578.1, Blood in stool, as the principal diagnosis. Assign code E934.2, Drugs, medicinals, and biological substances causing adverse effects in therapeutic use, anticoagulants, to describe the external cause.

• A code from category 286, Coagulation defects, is not appropriate for patients on anticoagulant therapy.

Coding Clinic, Second Quarter 2006, p. 17

Coumadin Coagulopathy – ICD-9-CM
Not Allowed

• Question: An 89-year-old male with a history of CHF and atrial fibrillation on Coumadin therapy was admitted for treatment of severe epistaxis. The physician documented, “Epistaxis secondary to Coumadin therapy.” Would a code from category 286, Coagulation defects, be appropriate? If not, how should this be coded?

• Answer: Assign code 784.7, Epistaxis, as the principal diagnosis with code E934.2, Drugs, medicinal and biological substances causing adverse effects in therapeutic use, agents primarily affecting blood constituents, anticoagulants, to identify the external cause of the nasal bleeding. Code V58.6, Long-term (current) use of anticoagulants, should be assigned as additional diagnoses.

• An increased risk for bleeding is a side effect associated with anticoagulant therapy. Coagulation deficiency (prolonged prothrombin time) is also an expected outcome of anticoagulant therapy.

− It should be noted that a code from the 286 series would not be used to identify patients on anticoagulant therapy.
− Therefore, code 286.5, Hemorrhagic disorder due to circulating anticoagulants, is an inappropriate code assignment for patients on Coumadin therapy.

Coding Clinic, Third Quarter 2004, p. 7
Bleeding Due to Coumadin Therapy
“Drug-Induced Hemorrhage Disorder”

**Question:** What is the code assignment for duodenal ulcer with hemorrhage due to Coumadin therapy, initial encounter?

- Is D68.32, Hemorrhagic disorder due to extrinsic circulating anticoagulant, assigned for bleeding that is due to anticoagulation therapy?

**Answer:** Assign codes K26.4, Chronic or unspecified duodenal ulcer with hemorrhage, D68.32, Hemorrhagic disorder due to extrinsic circulating anticoagulant, and T45.515, Adverse effect of anticoagulants.

- Depending on the circumstances of the admission, it may be appropriate to sequence either K26.4 or D68.32 as the principal or first-listed diagnosis.

Coding Clinic, First Quarter 2016, p. 14

Support for This Advice
ICD-10-CM Table of Diseases

Notice that drug-induced hemorrhagic disorder is part of D68.32. As such, warfarin-induced hemorrhagic disorder is part of ICD-10-CM whereas it was not in ICD-9-CM.

Bleeding Due to Coumadin Therapy
“Drug-Induced Hemorrhage Disorder”

**Question:** Should bleeding due to therapeutic anticoagulant be coded as a hemorrhagic disorder (category D68)?

**Answer:** For the most part, “hemorrhagic disorder” or “coagulation defects” must be specifically diagnosed and documented by the provider in order to assign codes at category D68. Other coagulation defects.

- However, for bleeding such as hemoptysis, hematuria, hematemesis, hematochezia, etc., that is associated with a drug, as part of anticoagulation therapy, assign code D68.32, Hemorrhagic disorder due to extrinsic circulating anticoagulants.

Coding Clinic, First Quarter 2016, p. 14
**DRGs w/o a code for an extrinsic circulating anticoagulant**

- **D68.32** as the PDx changes the MS-DRG and APR-DRG
- Postacute transfer policy doesn’t apply to MS-DRG 813
Procedure Issues

ICD-10-PCS Official Guidelines

ICD-10-PCS Official Guidelines for Coding and Reporting

2016

The Centers for Medicare and Medicaid Services (CMS) and the National Center for Health Statistics (NCHS), two departments within the U.S. Federal Government’s Department of Health and Human Services (HHS), provide the following guidelines for coding and reporting using the International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS). These guidelines should be used as a companion document to the official version of the ICD-10-PCS as published on the CMS website. The ICD-10-PCS is a procedure classification published by the United States for classifying procedures performed in hospital inpatient health care settings.

http://www.tinyurl.com/2016ICD10PCSGuidelines

ICD-10-PCS Official Guidelines

Independence of the Table

• A6 The purpose of the alphabetic index is to locate the appropriate table that contains all information necessary to construct a procedure code. The PCS Tables should always be consulted to find the most appropriate valid code.
• A7 It is not required to consult the index first before proceeding to the tables to complete the code. A valid code may be chosen directly from the tables.
Obstetrical Lacerations

Definitions

- **First-degree lacerations** involve injury to the skin and subcutaneous tissue of the perineum and vaginal epithelium only. The perineal muscles remain intact.
- **Second-degree lacerations** extend into the fascia and musculature of the perineal body, which includes the deep and superficial transverse perineal muscles and fibers of the pubococcygeus and bulbocavernous muscles. The anal sphincter muscles remain intact.
- **Third-degree lacerations** extend through the fascia and musculature of the perineal body and involve some or all of the fibers of the EAS and/or the IAS.
- **Fourth-degree lacerations** involve the perineal structures, EAS, IAS, and the rectal mucosa.

ICD-10-PCS Guideline B3.5

“If the root operation Excision, Repair or Inspection is performed on overlapping layers of the musculoskeletal system, the body part specifying the deepest layer is coded.”

In the context of a third-degree obstetric laceration, the anal sphincter muscle is beneath the perineal muscle and is therefore the deepest layer in this scenario.

External Approach

- **Open approach with percutaneous endoscopic assistance**
  - B5.2 Procedures performed using the open approach with percutaneous endoscopic assistance are coded to the approach Open.
  - Example: Laparoscopic-assisted sigmoidectomy is coded to the approach Open.
- **External approach**
  - B5.3a Procedures performed within an orifice on structures that are visible without the aid of any instrumentation are coded to the approach External.
  - Example: Resection of tonsils is coded to the approach External.
  - B5.3b Procedures performed indirectly by the application of external force through the intervening body layers are coded to the approach External.
  - Example: Closed reduction of fracture is coded to the approach External.
**Obstetrical Lacerations Approaches**

Coding Clinic, First Quarter 2016, pp.

- **First-degree perineal laceration**
  - Assign code 0HQ9XZZ, Repair perineum skin, external approach, for repair of a first-degree perineal laceration
  - No mention of repair of the vaginal mucosa
- **Second-degree perineal laceration**
  - Assign code 0HQN0ZZ, Repair perineum muscle, open approach, for repair of a second-degree perineal laceration
  - Doctor doesn’t have to document the repair of the muscle
- **Third-degree perineal laceration**
  - Assign code 0DQR0ZZ, Repair anal sphincter, open approach, for repair of a third-degree perineal laceration
  - Doctor doesn’t have to document the repair of the anal sphincter
- **Fourth-degree perineal laceration**
  - Assign code 0DQP0ZZ, Repair rectum, open approach, for the repair of a fourth-degree perineal laceration
  - Doctor doesn’t have to document the repair of the rectum

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**Debridement**

- Clinical or CPT
  - Merriam-Webster: The usually surgical removal of lacerated, devitalized, or contaminated tissue
  - Stedman’s, 23rd Edition: Excision of contused and devitalized tissue from a wound surface
  - CPT Assistant, May 2011: Includes removal of foreign material at the site of an open fracture and/or an open dislocation

- ICD-10-PCS Root Operations
  - Excision: Cutting out or off, without replacement, a portion of a body part
  - Extraction: Pulling or stripping out or off all or a portion of a body part by the use of force
  - Extirpation: Taking or cutting out solid matter from a body part
  - Destruction: The physical eradication of all or a portion of a body part by the direct use of energy, force, or a destructive technique
ICD-10-PCS Index to Procedures
Debridement

Guidelines

- B3.5 If the root operations Excision, Repair or Inspection are performed on overlapping layers of the musculoskeletal system, the body part specifying the deepest layer is coded.
  - Example: Excisional debridement that includes skin and subcutaneous tissue and muscle is coded to the muscle body part.

- A11 Many of the terms used to construct PCS codes are defined within the system. It is the coder’s responsibility to determine what the documentation in the medical record equates to in the PCS definitions. The physician is not expected to use the terms used in PCS code descriptions, nor is the coder required to query the physician when the correlation between the documentation and the defined PCS terms is clear.
  - Example: When the physician documents “partial resection” the coder can independently correlate “partial resection” to the root operation Excision without querying the physician for clarification.

ICD-10-PCS Reference Manual

http://tinyurl.com/2016ICD10pcsReference (3M)
Root Operation – Excision
Definition

Excision—Root operation B
Definition: Cutting out or off, without replacement, a portion of a body part
Explanation: The qualifier Diagnostic is used to identify excision procedures that are biopsies
Examples: Partial resection; liver biopsy

Excision is coded when a portion of a body part is cut out or off using a sharp instrument. All root operations that employ cutting to accomplish the objective allow the use of any sharp instrument, including but not limited to:
- Scalpel
- Wire
- Scissors
- Bone saw
- Electrocautery tip

While the ICD-10-PCS Reference Manual states that excisions can be done with scissors, does Coding Clinic trump it?

Coding Clinic Advice
Third Quarter 2015

Excisional debridement of the skin or subcutaneous tissue is the surgical removal or cutting away of such tissue, necrosis, or slough and is classified to the root operation “Excision.”
- Use of a sharp instrument does not always indicate that an excisional debridement was performed. Minor removal of loose fragments with scissors or using a sharp instrument to scrape away tissue is not an excisional debridement.
- Excisional debridement involves the use of a scalpel to remove devitalized tissue. Documentation of excisional debridement should be specific regarding the type of debridement.
- If the documentation is not clear or if there is any question about the procedure, the provider should be queried for clarification.

Coding Clinic Advice
Third Quarter 2015

Question: In terms of coding excisional debridement, does dissection mean the same as excisional? For example, the provider’s documentation states, “The debridement was sharp using knife dissection.”
Answer: No, knife dissection is not sufficient language to be able to code the root operation “Excision.”
- Knife dissection may only be referring to the means used to reach the procedure site, and doesn’t necessarily say what was done at the site.
- Query the physician for more information when the documentation only states knife dissection.
- Use of a sharp instrument does not always indicate that an excisional debridement was performed.
**Question:** Can you clarify what determines that a debridement in ICD-10-PCS is excisional? The progress note states, “I have debrided the abscess cavity, removing necrotic tissue and bone by sharp debridement.”

- Does the word “excision” need to be present as with ICD-9-CM?
- **Answer:** Yes, the documentation standard for coding excisional debridement in ICD-10-PCS is the same as it is for ICD-9-CM.
  - As with ICD-9-CM, the words “sharp debridement” are not enough to code the root operation Excision.
  - A code is assigned for excisional debridement when the provider documents “excisional debridement,” and/or the documentation meets the root operation definition or “excision” (cutting out or off, without replacement, a portion of a body part).

**Question:** If a physician documents “debridement of bone, fascia, or muscle” without specifying “excisional debridement,” can that be reported as excisional debridement?

- In order for the surgeon to get down into these areas, wouldn’t he or she need to excise/cut? What code should we report for debridement performed on bone, muscle, or fascia, if not specified as excisional?
- **Answer:** Coders cannot assume that the debridement of bone, fascia, or muscle is always excisional.
  - For example, if a patient suffers a traumatic open wound and fascia, muscle, or bone is exposed, an excisional debridement may not be performed.
  - ICD-10-PCS does not provide a default if the debridement is not specified as “excisional” or “nonexcisional.”
Anatomy Specificity

Lysis of Cardiac Adhesions
Anatomy Requirements in the Table

ICD-10-PCS requires documentation of what is being freed – note there’s no listing for “heart NOS”

Excision of Saphenous Vein
Requirement for Laterality/Type of Vein
Facility-Specific Guidelines

• **Question:** Please provide clarification for coding the harvest of the saphenous vein for coronary artery bypass grafting (CABG).
  - In the operative note, the physician documents harvest of left saphenous vein from the leg with no further specificity.
  - Is there any guidance when the documentation does not state upper/greater or lower/lesser saphenous vein?
• **Answer:** ICD-10-PCS does not have an “unspecified” or “not otherwise specified” designation for procedures performed on the saphenous vein.
  - If the documentation does not specify which saphenous vein was harvested, query the physician for clarification so that the appropriate body part may be reported.
  - Facilities may also work with providers to develop facility-specific coding guidelines, which will establish a default code based on common practice.

Areas Where Guidelines May Help

• Greater vs. lesser omentum
• Release of adhesions for heart
• High vs. low osmolar contrast
  - If facility only uses low osmolar contrast, then the policy can stipulate that only low osmolar contrast is used
• Others where there are frequent queries for anatomy

Subdural Hematomas
Subdural Hematoma

Hematoma
- subdural (traumatic) - see Injury, intracranial, subdural hemorrhage
  - newborn (localized) P52.8
- birth injury P10.0
- nontraumatic - see Hemorrhage, intracranial, subdural

Note that subdural hematomas are assumed to be traumatic unless documented to be atraumatic.
Subdural Hematoma
Chronic vs. Acute

• An acute subdural hematoma is characterized by a solid or gelatinous clot
  – A chronic subdural hematoma is typically composed of liquid matter rather than solid
• If the procedural report only describes evacuation of liquid or fluid, use the root operation “Drainage”
• The root operation “Extirpation” is used when solid matter is removed
  – If there is both drainage of liquid and cleaning out of solid matter, code only “Extirpation”
  – When this information is not available, “Extirpation” is the default

Subdural Hematoma
Open vs. Percutaneous

• Drainage: Taking or letting out fluids and/or gases from a body part
  – In ICD-10-PCS, an “open” approach is defined as cutting through the skin or mucous membrane and any other body layers necessary to expose the site of the procedure
  – The ICD-10-PCS defines “percutaneous” as entry, by puncture or minor incision, of instrumentation through the skin or mucous membrane and any other body layers necessary to reach the site of the procedure

Subdural Hematoma
MS-DRG Options

<table>
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<tr>
<th>Qualifiers</th>
<th>Traumatic subdural (Default)</th>
<th>Atraumatic subdural</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>DRG base w/CC</td>
<td>w/CC</td>
</tr>
<tr>
<td>Coma ≤ 1 hr</td>
<td>0.756</td>
<td>1.138</td>
</tr>
<tr>
<td>No proc</td>
<td>0.846</td>
<td>1.138</td>
</tr>
<tr>
<td>Burr hole or removal of fluid</td>
<td>Same as w/proc procedure if deemed to be “percutaneous”</td>
<td></td>
</tr>
</tbody>
</table>

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Other Coding Clinic Advice
Subdural Hematoma

• **Question:** The patient presented with a subdural hematoma, which was successfully treated by placement of a subdural evacuation portal system (SEPS).
  – During the placement of the drainage device, a burr hole was created and the SEPS drain bolt was then anchored in the bone. In ICD-10-PCS, what would be the approach value, “percutaneous” or “open?”

• **Answer:** The “percutaneous” approach is more appropriate since entry into the skull was done via puncture in order to reach the target area.
  – An “open” approach is not reported since the surgical site was not exposed by cutting through the body layers.
  – Assign the following ICD-10-PCS code for placement of the SEPS: 009430Z, Drainage of subdural space with drainage device, percutaneous approach.

Coding Rules
CDI Lessons

• Learn how to use the Index, Table, Guidelines, and Coding Clinic advice
  – Great bridge builders between CDI teams and coders

• **Coding Clinic** is available to all invested in documentation integrity
  – Must be advocated in light of the patient’s clinical indicators, the provider’s documentation, and official coding rules

Summary

• **Coding Clinic** is worth reading
• **Coding Clinic** is the Supreme Court
• You can ask **Coding Clinic** questions and get answers
• **Coding Clinic** is worth discussing with your coding staff
Thank you. Questions?

jkennedy@cdimm.com
Phone: 615-479-7021

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