

Presenter

HCPro

James S. Kennedy, MD, CCS, CDIP, CCDS President – CDIMD (near Nashville, TN) Credentials:

- Internal medicine the University of Tennessee
- AHIMA CCS 2001
- AHIMA CDIP 2012
- ACDIS CCDS 2015

Learning Objectives

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- 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

HCPro Foundations Coding Clinic for ICD-10-CM/PCS

The AHA Central Office Origins and Goals

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- 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

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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. Oden, RHIT, CCS, CCS-P
- Denene M. Harper, RHIA
- Medical advisors (CMS)
- Daniel J. Duvall, MD Songhai Barclift, MD, FACOG



- Coding consultants
 - Halima Zayyad-Matarieh, RHIA
 - Kathy White, RHIA
 - Cherrsse Ruffin, RHIT
 - Diane Komar, RHIT
 - Patricia D. Jones, RHIT

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The AHA Central Office Editorial Advisory Board (EAB)

- **HCPro**
- 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

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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

Donna 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

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
- 1983-2014 2012-present
- ICD-9-CM 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
 - Coding Clinic (CC), First Quarter 2011,

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Central Office on ICD-10-CM/PCS					
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Number 1		2016			
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Use of *Coding Clinic for ICD-9-CM*With ICD-10-CM/PCS

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- 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

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

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

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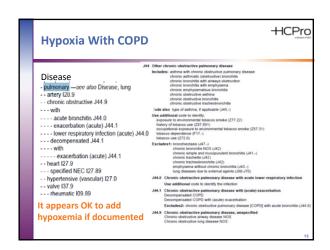
- Previously published ICD-9-CM advice that is still relevant and applicable to ICD-10 will continue to be re-published in Coding Clinic for ICD-10-CM/PCS
 - As with the application of any of the coding advice published in Coding Clinic, the information needs to be reviewed carefully for similarities 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

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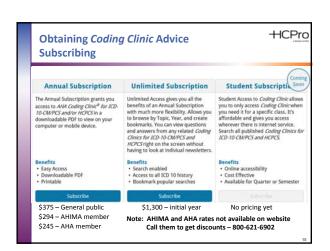
Use of *Coding Clinic for ICD-9-CM*With ICD-10-CM/PCS

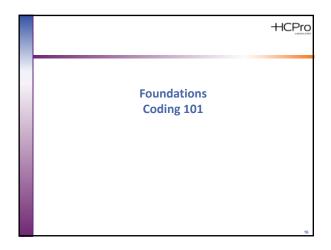
- Care must be exercised as the codes may have changed. Such change could be related to new codes, new combination codes, code revisions, a change in nonessential modifiers, or any other instructional note. This is particularly true as ICD-10-CM has many new combination codes that were not available 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.

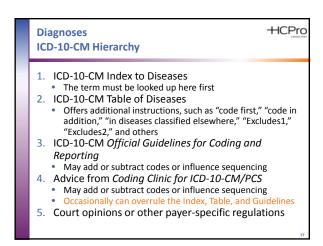
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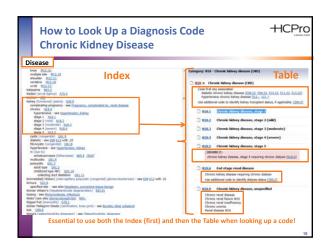


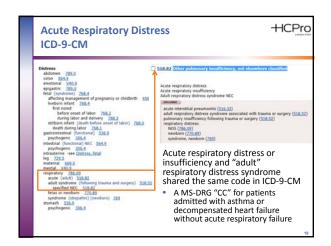
Send Your Own Questions to Coding Clinic Advisor Anyone can send in questions and do it online http://www.codingclinicadvisor.com Always best to submit a de-identified medical record Responses sent by U.S. mail (may take a while) It's FREE!

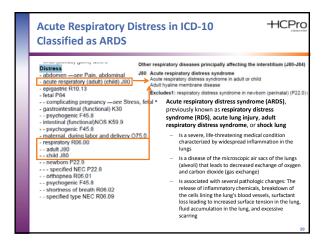








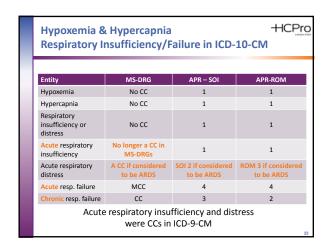


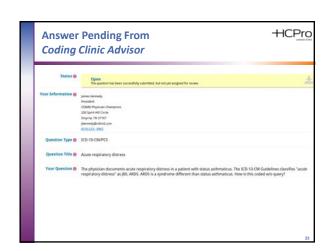


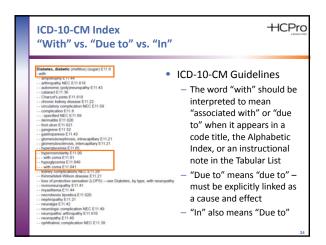
• (If the index is confusing), a basic rule of coding is that further research is done if the title of the code suggested by the index clearly does not identify the condition correctly. - Coding Clinic, Second Quarter 1991, p. 20 - Coding Clinic, Third Quarter 2004, pp. 5–6 - Coding Clinic, First Quarter 2013, pp. 13–14 • If the patient has acute respiratory distress but does not have ARDS, should J80, acute respiratory distress syndrome, be assigned?

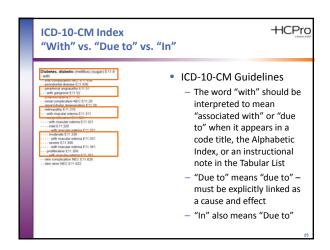
Title of Code Suggested by Index

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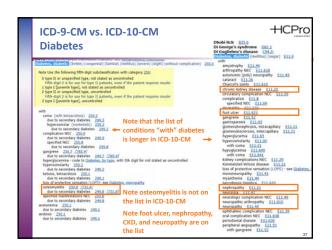








• According to the ICD-10-CM Official Guidelines for Coding and Reporting, the term "with" means "associated with" or "due to" when it appears in a code title, the Alphabetic Index, or an instructional note in the Tabular List, and this is how it's meant to be interpreted when assigning codes for diabetes 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



Diabetes "With" Osteomyelitis Coding Clinic, First Quarter 2016, p. 13

- **HCPro**
- 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.

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Diabetes "With" ESRD, Neuropathy, Foot Ulcer +CPro 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, endstage 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.

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Diabetes "With" Conditions

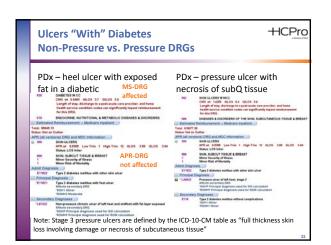
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- However, if the physician documentation specifies diabetes mellitus is not the underlying cause of the other condition, the condition should not be coded as a diabetic complication
 - When the coder is unable to determine whether a condition is related 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

• "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

HCPro Ulcers "With" Diabetes Diabetes, diabetic (mellitus) (sugar) E11.9 Clinical clue - - foot ulcer E11.621 It is important to recognize - - skin complication NEC E11.628 that not all ulcers in diabetic - - skin ulcer NEC E11.622 patients are diabetic ulcers. · Note that in ICD-10-CM, · Diabetic ulcers of the foot any skin ulcer occurring in generally start on the toes diabetes is linked to and move upward. diabetes unless the · Diabetic ulcers do not physician explicitly states usually start on the heel. that the ulcer is due to Ulcers of the heel are another cause (e.g., almost always decubiti. pressure ulcer, venous Coding Clinic, First Quarter 2004, pp. 14–15 insufficiency).



HCPro 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 **HCPro Respiratory Distress Syndrome and Respiratory Failure of Newborn** P22 Respiratory distress of newborn Excludes1: respiratory arrest of newborn (P28.81 respiratory failure of newborn NOS (P28.5) P22.0 Respiratory distress syndrome of newborn Cardiorespiratory distress syndrome of newborn Hyaline membrane disease Idiopathic respiratory distress syndrome [IRDS or RDS] of newborn Pulmonary hypoperfusion syndrome Respiratory distress syndrome, type I P22.1 Transient tachypnea of newborn Idiopathic tachypnea of newborn Respiratory distress syndrome, type II Wet lung syndrome P22.8 Other respiratory distress of newborn P22.9 Respiratory distress of newborn, unspecified **HCPro 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

http://www.cdc.gov/nchs/data/icd/Interim advice updated final.pdf

an Excludes1 note

Excludes1 Note Caveat Coding Clinic, Fourth Quarter 2015

- **HCPro**
- **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.
 - with the R4U-R4b 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 I6O-I60 (crebrovascular diseases) has an Excludes1 note for traumatic intracranial hemorrhage (S06.-). Codes in I6O-I69 should not be used for a diagnosis of traumatic intracranial hemorrhage.
 - However, if the patient has both a current traumatic intracranial hemorrhage and sequela from a previous stroke, then it would be appropriate to assign both a code from SO6- and I69-.

http://www.cdc.gov/nchs/data/icd/Interim advice updated final.pdf

Excludes1 Note Neutropenia and Pancytopenia

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Neutropenia With Pancytopenia Coding Clinic, Fourth Quarter 2014, pp. 22-23

- **HCPro**
- 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, T45.1X5A, Adverse 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 Excludes! note at category D61, Other complete clinical picture. Ho arrow failure syndromes, prohibits assigning nia 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.

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Take-Home L	Lesson +CPro	
Excludes1 W		
Consider de	eveloping written policies of what common	
	conditions" are not "related to each	
other"		
	examples are those published by <i>Coding Clinic</i> and e.g., neutropenia and pancytopenia; mental	
	with R40–R46 codes)	
	versial example may be acute respiratory failure	-
	iratory distress syndrome	
	maintain respiratory failure is related; some do not	
	orth getting an opinion from your neonatologists rhaps <i>Coding Clinic Advisor</i> would be of help	
	have in place for audit defense	
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	+CPro	
Code	ing Clinic's Impact on Auditors	
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	Specific Regulations ++CPro	
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These include	ignment, even based on provider assignment. de:	
- Recovery A	Audit Contractors (RAC) – Inpatient DRGs	
 Risk Adjust 	tment Data Validation (RADV) – Outpatient HCCs Is the record legible?	
	Is the record from a valid provider type? (Hospital inpution, hospital	
Cample	outpatient' physician) Are there valid credentials and/or is there a valid physician specialty	
Sample	documented on the record?	
criteria	Does the record contain a signature from an acceptable type of physician specialist?	
for RADV	If the outpatient/physician record does not contain a valid credential and/or signature, is there a completed CMS-Generated Attestation for this date of service?	
	Is there a diagnosis on the record?	
	Does the diagnosis support an HCC?	

Payer Preference

HCPro

Coding Clinic ICD-10, First Quarter 2014 pp. 16-17

- 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.

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Payer Preference

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Coding Clinic ICD-10, First Quarter 2014 pp. 16-17

- The following advice is provided to help providers resolve coding disputes with payers:
 - 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.
 - 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.
 - 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.
 - Keep a permanent file of the documentation obtained regarding payer coding policies. It may come in handy in the event of an audit.

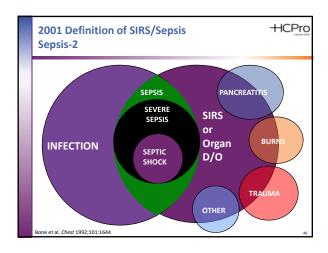
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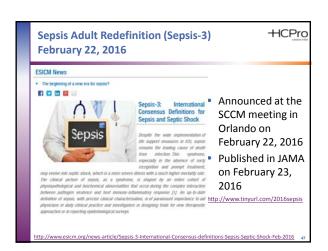
Sepsis-2 vs. Sepsis-3 Clinical Validity

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- 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. 19 The Editorial Advisory Board (EAB) for Coding Clinic has become aware of a pattern of documentation problems concerning patients transferred to the LTCH 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."

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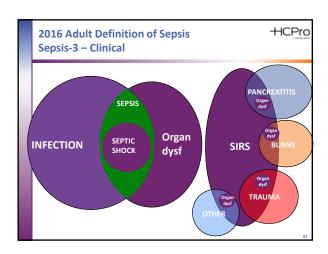
Sepsis-3 Adult Redefinition Requirement for Organ Dysfunction Sepsis is now defined as a "life-threatening organ dysfunction due to a dysregulated host response to infection" In this new definition the concept of the non-homeostatic host response to infection is strongly stressed while the SIRS criteria 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

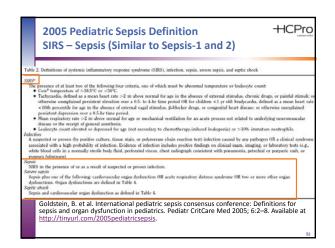
Sepsis-3 Adult Redefinition Organ Dysfunction – SOFA Scores

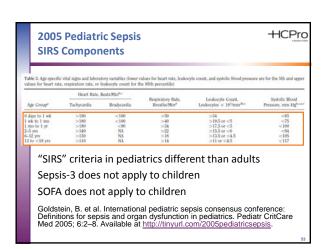
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- The key element of sepsis-induced organ dysfunction is defined by "an acute change in total SOFA score ≥ 2 points consequent to infection, reflecting an overall mortality rate of approximately 10%"
 - The baseline Sepsis-related Organ Failure Assessment (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

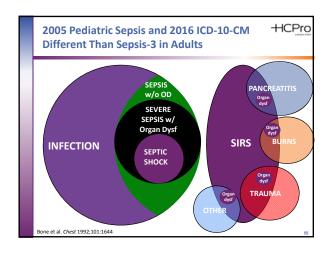
| Sepsis-3 Adult Redefinition | SOFA Score | SOFA SCORE

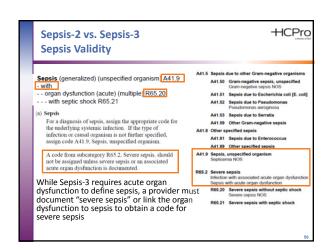


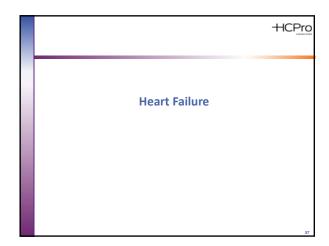




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Heart Failure w/Preserved EF (HFpEF) Heart Failure w/Reduced EF (HFrEF)

- **HCPro**
- Question: If a physician documents heart failure with preserved ejection fraction (HFpEF), or heart failure with preserved systolic function, or alternatively heart failure with reduced ejection fraction (HFrEF), heart failure with low ejection fraction, heart failure with reduced systolic function, or other similar terms, 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 newel 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

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

HCPro

- 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

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

HCPro

- 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

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Kennedy note: The provider must still state "acute," "decompensated," or "acute on chronic" for a coder to use the higher-weighted codes

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Bleeding Due to Coumadin Therapy "Drug-Induced Hemorrhage Disorder"

- **HCPro**
- 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.

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

HCPro

D63.31 Hemorrhagic disorder dae to intrinsic circulating anticoagulants, antibodies, or inhibits D63.311 Acquered hemophilia Autoimmune hemophilia Autoimmune hemophilia Autoimmune hemophilia Secretary hemophilia

Automovine Inhaltors to cotting factors

Secondary Inmofalia

DEA.325 Antiphosphologial authorizy with Remorrhagic disorder

Loss introducidate (LAC), with Inhaltoridagic disorder

Loss introducidate (LAC), with Inhaltoridagic disorder

Excludest antiphosphologial entition, finding without diagnosis (PTA 6)
antiphosphologial entition, finding without diagnosis (PTA 6)
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largua entitionagiant (LAC) with Proprocessipation state (PSA 6) in
largua entitionagiant (LAC) with Proprocessipation state (PSA 6) in
systemic Lope or phematisms (LSL) entitle forting without diagnosis
systemic Lope or phematisms (LSL) entitle or with year compalies state

systemic Lope or spermatisms (LSL) entitle or with year with years capabile state.

168.318 Other hemorrhagic disorder due to intrinsic circulating anticoagulant or shibibliors
and the shibibliors
Authorito disorder due to intrinsic increase in antitrombin Hemorrhagic disorder due to intrinsic increase in antitrombin Hemorrhagic disorder due to intrinsic increase in artifumbin Hemorrhagi

Drug-induced hemorrhagic disorder
Hemorrhagic disorder due to increase in anti-lla
Hemorrhagic disorder due to increase in anti-lla
Hyporrhagatinemia
Hyporrhagatinemia

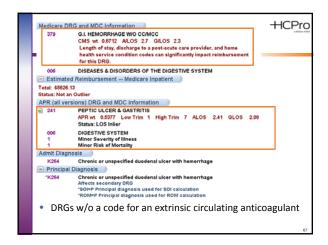
Notice that drug-induced hemorrhagic disorder is part of D68.32 As such, warfarininduced hemorrhagic disorder is part of ICD-10-CM whereas it was not in ICD-9-CM

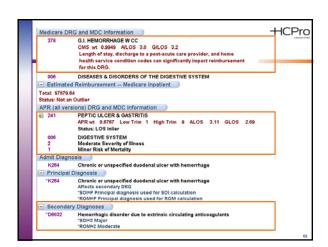
Bleeding Due to Coumadin Therapy "Drug-Induced Hemorrhage Disorder"

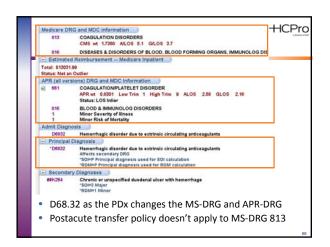
HCPro

- 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







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+HCP <u>ro</u>	
	-
Procedure Issues	
70	
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ICD-10-PCS + HCPro 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 (DHHS) 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	
http://www.tinyuri.com/2016icD10PcSguidelines	
	7
ICD-10-PCS Official Guidelines +CPro	
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.	

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Obstetrical Lacerations	
п	
	1
Obstetrical Lacerations Definitions HCPro	
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 bulbocavernosus is coded." 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."	
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.	
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External Approach + HCPro	
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	

HCPro Obstetrical Lacerations Approaches Coding Clinic, First Quarter 2016, pp. First-degree perineal laceration Assign code OHQ9XZZ, 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 0KQM0ZZ, 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 ODQROZZ, 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 ODQPOZZ, Repair rectum, open approach, for the repair of a fourth-degree perineal laceration Doctor doesn't have to document the repair of the rectum **HCPro Debridement HCPro Debridement Definition** ICD-10-PCS Root Operations Clinical or CPT Merriam-Webster: The usually Excision: Cutting out or off, surgical removal of lacerated, devitalized, or contaminated 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

Destruction: The physical eradication of all or a portion

of a body part by the direct

use of energy, force, or a destructive

part

tissue

Stedman's, 23rd Edition: Excision of contused and

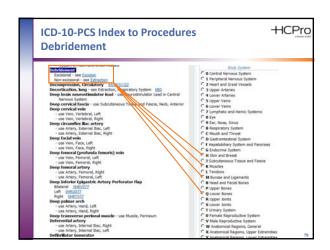
devitalized tissue from a

material at the site of an open fracture and/or an open

wound surface

CPT Assistant, May 2011:
Includes removal of foreign

dislocation



HCPro ICD-10-PCS Guidelines A11 Many of the terms used to construct PCS codes are defined within the system. It is the coder's B3.5 If the root operations Excision, Repair or Inspection are 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. 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.
- 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.

HCPro ICD-10-PCS **Reference Manual** ICD-10-PCS Reference Manual http://tinyurl.com/2016ICD10pcsReference (3M)

HCPro 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 biopsie Examples: Partial nephrectomy, 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 Bone saw While the ICD-10-PCS Reference Manual states that excisions can be done with scissors, does Coding Clinic trump it? **HCPro 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

HCPro

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.

Coding Clinic AdviceThird Quarter 2015

HCPro

- 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).

Coding Clinic Advice Third Quarter 2015

HCPro

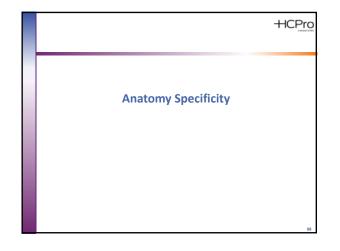
Question: If a physician documents "debridement of bone, fascia, or muscle" without specifying "excisional debridement," can that be reported as excisional debridement?

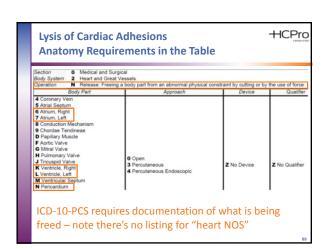
 In order for the surgeon to get down into these areas, wouldn't he or she need to excise/cut? What code should we report for debridement performed on bone, muscle, or fascia, if not specified as excisional?

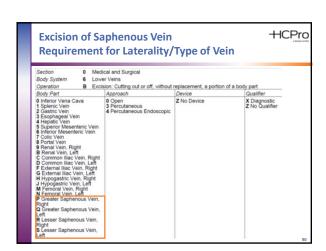
Answer: Coders cannot assume that the debridement of bone, fascia, or muscle is always excisional.

- 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."

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Coding Clinic ICD-10, Third Quarter 2014, p. 8 HCPro **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. **HCPro 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 **HCPro Subdural Hematomas**

Subdural Hematoma Options 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

ICD-10 Code	Description	Subcategory	MS-DRG MCC/CC	MS-DRG HAC	APR-DRG SOI	APR R0
16200	Nontraumatic subdural hemorrhage, unspecified		MCC		4	
6201	Nontraumatic acute subdural hemorrhage		MCC		4	
16202	Nontraumatic subacute subdural hemorrhage		MCC		4	
16203	Nontraumatic chronic subdural hemorrhage		MCC		4	
P100	Subdural hemorrhage due to birth injury		MCC		3	
S065X0A	Traumatic subdural hemorrhage without LOC	Initial	MCC	HAC	2	
S065X0D		Subsequent			1	
S065X0S		Seguela			2	
S065X1A		Initial	MCC	HAC	2	
S065X1D		Subsequent			1	
S065X1S		Sequela			2	
S065X2A		Initial	MCC	HAC	2	
S065X2D	Traumatic subdural hemorrhage with LOC of 31 minutes to 59 minutes	Subsequent			1	
S065X2S	Dy minutes	Sequela			2	
S065X3A	Transmatic and discal homosphere with LOC of 1 hours to E	Initial	MCC	HAC	3	
S065X3D	Traumatic subdural hemorrhage with LOC of 1 hour to 5 hours 59 minutes.	Subsequent			1	
S065X3S	nours by minutes,	Seguela			2	

Sul	odural Hematoma				+IC	P
Tab						2.000
ICD-10 Code	Description	Subcategory	MS-DRG MCC/CC	MS-DRG HAC	APR-DRG SOI	APF R
S065X4A	Traumatic subdural hemorrhage with LOC of 6 hours to 24	Initial	MCC	HAC	3	\perp
S065X4D	hours.	Subsequent			1	┸
S065X4S	ilours,	Sequela			2	┸
S065X5A	Traumatic subdural hemorrhage with LOC > 24 hours with	Initial	MCC	HAC	4	╙
S065X5D	return to pre-existing conscious level	Subsequent			1	╙
S065X5S	retain to pre existing conscious level	Sequela			2	┸
S065X6A	Traumatic subdural hemorrhage with LOC > 24 hours without	Initial	MCC	HAC	4	╙
S065X6D	return to pre-existing conscious level with patient surviving,	Subsequent			1	╄
S065X6S		Sequela			2	+
S065X7A	Traumatic subdural hemorrhage with LOC of any duration with	Initial	MCC	HAC	- 4	+
S065X7D	death due to brain injury before regaining consciousness			_	1	+
S065X7S	, , ,	Sequela			2	+
S065X8A S065X8D	Traumatic subdural hemorrhage with LOC of any duration with	Initial	MCC	HAC	1	+
S065X8D S065X8S	death due to other cause before regaining consciousness	Subsequent		_		+
S065X8S		Sequela	MCC	HAC	2	+
S065X9A S065X9D	Transmotic authorized homosphane with 1 OC of concession discrete	Subsequent	mcc	nAC	1	+
S065X9D	Traumatic subdural hemorrhage with LOC of unspecified duration	Seguela			2	+
DOUDNAD		Seylleld				-
	encounter: First diagnosis or active treatment p	hase				

Subdural Hematoma Chronic vs. Acute

HCPro

- 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

Coding Clinic ICD-10, Third Quarter 2015 pp. 10-11

Subdural Hematoma Open vs. Percutaneous

HCPro

- 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

Coding Clinic ICD-10, Third Quarter 2015 pp. 10-12

HCPro Subdural Hematoma MS-DRG Options tic subdural (Default) w/o CC DRG base w/o CC w/cc w/MCC DRG base w/cc w/mcc 064-066 INTRACRANIAL HEMORRHAGE/ 085-087 TRAUMATIC STUPOR AND COMA, COMA Coma < 1 hr 0.7918 1.1394 2.0357 CEREBRAL INFARCTION (coma excluded as MCC if subdural is PDx) <1 HOUR 0.7574 1.059 1.7326 Coma≥1 hr No proc 0.8469 1.1306 2.0170 Burr hole only w/remov of fluid 025-027 Burr hole 025-027 CRANIOTOMY AND CRANIOTOMY removal of solid matter OR open AND ENDOVASCULAR INTRACRANIAL PROCEDURES ENDOVASCULAR INTRACRANIAL PROCEDURES 2.285 2.996 4.297 2.285 2.996 4.29

Other *Coding Clinic* Advice Subdural Hematoma

HCPro

- 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 Clinic ICD-10, Third Quarter 2015 p. 12

Coding Rules CDI Lessons

HCPro

- 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



Photo credit: Wikipedi http://en.wikipedia.org/wiki/Bridg

Summary

HCPro

- 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

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Thank you. Questions?	
jkennedy @cdimd.com Phone: 615-479-7021	
In order to receive your continuing education certificate(s) for this program, you must complete the online evaluation. The link can be found in the continuing education section at the front of the program guide.	
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