Critical *Coding Clinic* ICD-10-CM/PCS Updates: An Insider’s Look

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Learning Objectives

• At the completion of this educational activity, you will be able to:
  – Develop strategies for working with your providers to address potential documentation gaps that will need to be addressed for ICD-10 implementation
  – Review coding and documentation updates necessary for a successful transition to ICD-10-CM/PCS
  – Explain critical guidance issued by Coding Clinic with a focus on what CDI specialists will need to clarify with physicians

Coding Clinic and ICD-10

• 4th Quarter 2012 issue started including ICD-10-CM/PCS questions
• No plans to translate all previous issues of Coding Clinic for ICD-9-CM into ICD-10-CM/PCS
  – Many of the questions published arose out of the need to provide clarification on the use of ICD-9-CM and would not be readily applicable to ICD-10-CM/PCS
  – Published questions only included information necessary to assign ICD-9-CM codes
What Coding Clinic Is NOT

- Clinical criteria for establishing diagnosis
  - *Coding Clinic* provides clinical “clues,” not “criteria”
- Replacement for physician documentation
  - *Coding Clinic* may identify what documentation may be used for coding
  - *Coding Clinic* cannot arbitrate issues of clinical validity
  - All coding should be supported by provider documentation as defined by the Official Coding Guidelines
    • Others may question whether clinical documentation supports a documented diagnosis, but *Coding Clinic* will provide codes for documented diagnoses
- Clinical definitions
  - *Coding Clinic* has no authority to provide clinical definitions
What’s Not Changing – Clinical Information

- Signs and symptoms integral to a condition
  - Example:
    - Hypoxia is not inherent in COPD. When hypoxia is associated with COPD, it is appropriate to assign code 799.02, Hypoxemia, as an additional diagnosis if desired.

  *Coding Clinic*, Third Quarter 2009, p. 20

What’s Not Changing – Clinical Information

- *Coding Clinic* information may still be useful to understand clinical clues regarding signs or symptoms that may be integral (or not) to a condition
- However, care should be exercised as ICD-10-CM has new combination codes as well as instructional notes that may or may not be consistent with ICD-9-CM
What’s Not Changing – Clinical Information

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

  
  Coding Clinic, First Quarter 2010, p. 5

Coding Clinic Documentation

• Coding Clinic advice regarding documentation issues over the years has focused on what documentation can be used and was not specific to a coding system

  Coding Clinic for ICD-10-CM and ICD-10-PCS, First Quarter 2014
What’s Not Changing – Documentation Issues

• Associated conditions and documentation of a linkage
  – 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.

What’s Not Changing – Documentation Issues

• Associated conditions and documentation of a linkage (cont.)
  – 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.
Physician documentation – which physicians?
- Code assignment may be based on other physician (i.e., consultants, residents, anesthesiologist, etc.) documentation as long as there is no conflicting information from the attending physician.
- Medical record documentation from any physician involved in the care and treatment of the patient, including documentation by consulting physicians, is appropriate for the basis of code assignment.

Coding Clinic, First Quarter 2004, pp. 18–19
Republished Coding Clinic for ICD-10-CM and ICD-10-PCS, First Quarter 2014

Resident’s documentation – resident
- The issue of whether a resident’s documentation needs to be confirmed by the attending physician is best addressed by the hospital’s internal policies, medical staff bylaws, and/or any other applicable local/state/federal regulations

Coding Clinic, Third Quarter 2008, p. 3
Republished Coding Clinic for ICD-10-CM and ICD-10-PCS, First Quarter 2014
What’s Not Changing – Documentation Issues

• Physician documentation – resolving conflicts
  – A physician query is not necessary if a physician involved in the care and treatment of the patient, including consulting physicians, has documented a diagnosis and there is no conflicting documentation from another physician.
  – If documentation from different physicians conflicts, seek clarification from the attending physician, as he or she is ultimately responsible for the final diagnosis. This information is consistent with the American Health Information Management Association’s (AHIMA) documentation guidelines.

  Coding Clinic, First Quarter 2004, pp. 18–19
  Republished Coding Clinic for ICD-10-CM and ICD-10-PCS, First Quarter 2014

What’s Not Changing – Documentation Issues

• Physician documentation – which documents?
  – Documentation is not limited to the face sheet, discharge summary, progress notes, history and physical, or other report designed to capture diagnostic information. This advice refers only to inpatient coding.

  Coding Clinic, Second Quarter 2000, pp. 17–18
  Republished Coding Clinic for ICD-10-CM and ICD-10-PCS, First Quarter 2014
What’s Not Changing – Documentation Issues

- **Cancer staging**
  - It is appropriate to use the completed cancer staging form for coding purposes when it is authenticated by the attending physician

  *Coding Clinic*, Second Quarter 2010, pp. 7–8
  Republished *Coding Clinic for ICD-10-CM and ICD-10-PCS*, First Quarter 2014

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What’s Not Changing – Documentation Issues

- **Midlevel provider documentation**
  - It would be appropriate to use the health record documentation of other providers, such as nurse practitioners and physician assistants, as the basis for code assignment to report new diagnoses, if they are considered legally accountable for establishing a diagnosis within the regulations governing the provider and the facility
  - The Official Guidelines for Coding and Reporting define a provider as the individual legally accountable for establishing a diagnosis

  *Coding Clinic*, Fourth Quarter 2004, p. 138
What’s Not Changing – Documentation Issues

• Documentation discrepancy for gestational age
  – For the newborn, assign the appropriate codes for the gestational age based on the attending provider’s (e.g., pediatrician) documentation. Different providers (e.g., obstetrician and pediatrician) may utilize different criteria in determining weeks of gestation for the mother versus the gestational age of the infant.

  *Coding Clinic*, First Quarter 2009, p. 12

Coding on the Basis of Up or Down Arrows

• Do not code on the basis of up and down arrows
  – Can have variable interpretations and do not necessarily mean "abnormal"
  – Could simply be indicating change (including improvement) over past results
  – Query provider regarding meaning and request that the appropriate documentation of a condition or diagnosis be provided
  – Applies for both inpatient and outpatient admissions

  *Coding Clinic for ICD-10-CM and ICD-10-PCS*, First Quarter 2014
Acute Exacerbation of Asthma and Status Asthmaticus

- Every effort was made to carry over the ICD-9-CM guidelines and concepts into ICD-10-CM, unless there was a specific change in ICD-10-CM that precluded the incorporation of the same concept into ICD-10-CM
  - However, some of the guidelines in ICD-9-CM included information that may have been clinical in nature (as in the example noted in the question) [Section I.C8.a.4, “Acute exacerbation of asthma and status asthmaticus”] and therefore not appropriate for coding guidelines

_Coding Clinic_, Fourth Quarter 2012, p. 99

Acute Exacerbation of Asthma and Status Asthmaticus

- Acute exacerbation of asthma and status asthmaticus (cont.)
  - With respect to the coding of acute exacerbation of asthma and status asthmaticus together, only the code for the more severe condition (i.e., status asthmaticus) should be assigned

_Coding Clinic_, Fourth Quarter 2012, p. 99
Long-Term Care

- The "first-listed diagnosis" is the diagnosis which is chiefly responsible for the admission to, or continued residence in the nursing facility and should be sequenced first
  - If coding diagnoses during the resident’s stay, it is the condition chiefly responsible for the continued stay in the facility

*Coding Clinic, Fourth Quarter 2012, pp. 90–98*

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Using the X-Ray for Specificity

- If the x-ray report provides additional information regarding the site for a condition that the provider has already diagnosed, it would be appropriate to assign a code to identify the specificity that is documented in the x-ray report
Using the X-Ray for Specificity – Inpatient

- Abnormal findings are not coded and reported unless the provider indicates their clinical significance.
- If the finding is outside the normal range and the attending provider has ordered other tests to evaluate the condition or prescribed treatment, it is appropriate to ask the provider whether the abnormal finding should be added.

Using the X-Ray for Specificity – Outpatient

- If the diagnostic tests have been interpreted by a physician, and the final report is available at the time of coding, it is appropriate to code any confirmed or definitive diagnosis(es) documented in the interpretation.
- Do not code related signs and symptoms as additional diagnoses.

Coding Clinic, First Quarter 2013, pp. 28–29
Documentation of “Decompensated”

- As previously stated, “decompensated” indicates that there has been a flare-up (acute phase) of a chronic condition

Coding Clinic, Second Quarter 2013, p. 33

Lysis of Adhesions

- Carefully review entire operative report to determine clinical significance of the adhesions and complexity of the lysis of adhesions
- Code when
  - Documented obstruction, lysis of adhesions is the major procedure performed
  - Strong band of adhesions prevent surgeons from access to organ being removed, requiring lysis before operation can proceed
    - Unless instructional notes in Index, Tabular List, or guidelines preclude separate coding
Lysis of Adhesions

• Do not code when
  – Minor adhesions exist and are easily lysed as part of the principal procedure
  – Simply procedural steps necessary to reach the operative site
  – Incidental finding

Republished Coding Clinic for ICD-10-CM and ICD-10-PCS, First Quarter 2014

Facility-Specific Coding Guidelines

• Should not replace physician documentation
  – Can guide when to query physicians for clarification, but not interpret abnormal findings or replace physician documentation or query
  – Must be applied consistently to all records coded
  – Must not conflict with Official Guidelines

Coding Clinic for ICD-10-CM and ICD-10-PCS, First Quarter 2014
Coding Disputes With Payers

- Traditionally Coding Clinic does not address coding for reimbursement
- Resolving coding disputes with payers
  - Coding dispute or coverage or payment issue?
  - If payer policy conflicts with official coding rules or guidelines, attempt to resolve issue with payer
  - If payer refuses to change policy, obtain payer requirements in writing
    - If the payer refuses to provide their 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

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Inconclusive Diagnoses and Coding for Physician Services

- Use Diagnostic Coding and Reporting Guidelines for Outpatient Services (Hospital-Based and Physician Office) regardless of setting where physician services were provided (including hospital inpatient)
- Do not code diagnoses documented as "probable," "suspected," "questionable," "rule out," or "working diagnosis"
  - Code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit

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- Documentation for the current encounter should clearly reflect those diagnoses that are current and relevant for that encounter.

- Conditions documented on previous encounters may not be clinically relevant on the current encounter. The physician is responsible for diagnosing and documenting all relevant conditions.

- A patient’s historical problem list is not necessarily the same for every encounter/visit.

- It is the physician’s responsibility to determine the diagnoses applicable to the current encounter and document in the patient’s record.

Assigning Codes Using Prior Encounters

- When reporting recurring conditions and the recurring condition is still valid for the outpatient encounter or inpatient admission, the recurring condition should be documented in the medical record with each encounter/admission.

- However, if the condition is not documented in the current health record, it would be inappropriate to go back to previous encounters to retrieve a diagnosis without physician confirmation.

Coding Clinic, Third Quarter 2013, pp. 27–28
Query Forms

- Will need to redesign physician queries
- Coders and documentation specialists most likely already know where the gaps in documentation are
  - Work together to watch for gaps and work on closing those gaps now!
- Review query form inventory

Dictation/Transcription

- Much more difficult (if not impossible in some instances) to code without an operative report
- Do you want your coders to wait for the dictation and/or transcription of the report?
- Filing (if working with paper)
- Address any workflow deficiencies up front
Number of ICD-9-CM and ICD-10 Codes for Diagnoses and Procedures

So where is the additional detail?

Some Areas Requiring Documentation Improvement
General ICD-10-CM

- Laterality: Most likely documented, especially with injuries, but other areas?
- Combination codes for commonly associated conditions and symptoms or manifestations
- Changes in time frames associated with familiar codes

Degenerative Disc Disease

- Currently, ICD-10-CM does not provide a code for unspecified degenerative disc disease. Query the provider for clarification regarding the affected region.
  - The National Center for Health Statistics (NCHS) is aware of the discrepancies in the index and has agreed to review and correct the index entries

_Coding Clinic_, Third Quarter 2013, p. 22
Seventh Character Determination

- Initial vs. subsequent encounter vs. sequela
  - Injuries
  - Poisoning, adverse effects, and underdosing
  - Most external cause codes (except for place of occurrence, activity, or status)

Fractures

- In addition to initial, subsequent, or sequela:
  - Initial: Open vs. closed
    - Gustilo classification of open fractures
      - S52 Forearm
      - S72 Femur
      - S82 Lower leg, including ankle
  - Subsequent
    - Routine healing
    - Nonunion
    - Malunion
Myocardial Infarctions Subsequent Encounters

- Does the patient require continued care for acute myocardial infarction (AMI)?
  - Is it within 4 week time frame?
  - **New concept:** Has the patient suffered a NEW AMI within the 4 week time frame of the initial AMI?
    - The sequencing depends on the circumstances of the encounter
- Is the myocardial infarction old or healed, not requiring further care?

Obstetrics Documentation

- Trimester
- Number of weeks of gestation
  - The date of the admission should be used to determine weeks of gestation for inpatient admissions that encompass more than one gestational week (*Coding Clinic*, Second Quarter 2013, pp. 33–34)
- Multiple gestation complication – 7th character for which fetus was affected (e.g., fetus 2)
- Preexisting conditions vs. due to pregnancy
- Diabetes – diet controlled, insulin controlled, or unspecified control
Fetal Identification – 7th Character

- Guidelines: 7th character “0” for
  - Single gestations
  - When the documentation is insufficient to determine the fetus affected and it’s not possible to obtain clarification
  - When it’s not possible to clinically determine which fetus is affected

- Coding Clinic:
  - Fetus A should be equated with fetus 1, fetus B should be equated with fetus 2, and so on
  - There is no expectation that the same fetus number or alphabetical character be consistently carried over from one admission to another
  - Identification of the fetus, whether by number or alphabetical character, is based on the provider documentation

  Coding Clinic, Fourth Quarter 2012, pp. 107–108

Urosepsis

- Alphabetic Index – code to condition
  - Generalized sepsis?
  - Urine contaminated by bacteria, bacterial byproducts, or other toxic material but without other findings?

- ICD-10-CM no longer defaults to urinary tract infection
Adverse Effects, Poisoning, Underdosing, and Toxic Effects

- Combination codes that include the substances related to adverse effects, poisonings, toxic effects, and underdosing, as well as the external cause
  - Will require knowing intent: accidental, intentional self-harm, assault, undetermined
    - New information for states where external cause coding is not mandated

New Concept: Underdosing

- Taking less of a medication than is prescribed
  - Provider or manufacturer
  - Never assigned as principal or first-listed
    - If relapse, medical condition itself is coded
  - Noncompliance or complication of care codes are used with underdosing code to indicate intent, if known.
**Rehabilitation**

- Guideline Section II. Selection of Principal Diagnosis:
  - Admission/encounter is for rehabilitation:
    - Sequence first the code for condition for services performed
      - Ex.: Rehab for right-sided dominant hemiplegia following CVA, report code I69.351, Hemiplegia and hemiparesis, following cerebral infarction affecting right dominant side.
    - If condition no longer present, report first the appropriate aftercare code
      - Ex.: Severe degenerative osteoarthritis of hip, had hip replacement, and now encounter for rehab. Report code Z47.1, Aftercare following joint replacement surgery.

**ICD-10-PCS – Characters (Med/Surg)**

All 7 characters of an ICD-10-PCS code are required to code. Are all of them documented today?
General ICD-10-PCS

• Crucial to understand 31 root operations
  – Is the documentation present to determine?
• Approach
  – No defaults for unspecified approach
• Specific body part
  – Laterality (e.g., right ovary, left ovary, or bilateral ovaries; no default for unspecified ovary; same for fallopian tubes)
  – Greater granularity (vessels, muscles, nerves)

Challenging Root Operations Where Documentation Is Important

• Resection vs. excision
  – All or a portion of a body part removed (based on ICD-10-PCS values).
    • For example, lymph nodes – a few nodes or entire lymph node chain?
• Extirpation vs. fragmentation
  – For example, lithotripsy: Were the fragments removed? If yes, extirpation; if not, fragmentation.
Challenging Root Operations Where Documentation Is Important

• Occlusion vs. restriction
  – What is the objective, completely close (occlusion) or partially close (restriction)?

• Change vs. removal vs. revision
  – Taking out device (removal)
  – Exchanging device without cutting/puncturing (change)
  – Correcting malfunctioning, displaced device (revision)

Challenging Root Operations Where Documentation Is Important

• Amputations: Is the body part identified in sufficient detail to select qualifier?
  – Upper arm and upper leg (portion of the shaft of the humerus or femur amputated)
    • High: Proximal portion
    • Mid: Middle portion
    • Low: Distal portion
  – Foot
    • Complete or partial?
    • 1st, 2nd, 3rd, 4th, or 5th ray?
Challenging Root Operations Where Documentation Is Important

- Amputations: Is the body part identified in sufficient detail to select qualifier? (cont.)
  - Thumb, finger, or toe
    - Complete: Metacarpophalangeal/metatarsal-phalangeal joint
    - High: Anywhere along the proximal phalanx
    - Mid: Through the proximal interphalangeal joint or anywhere along the middle phalanx
    - Low: Through the distal interphalangeal joint or anywhere along the distal phalanx

Lysis of Abdominal Adhesions

- In the root operation release, the body part value coded is the body part being freed, and not the tissue being manipulated or cut to free the body part
  - Lysis of intestinal adhesions
    - Small intestine
    - Duodenum
    - Jejunum
    - Ileum
    - Ileocecal valve
    - Large intestine
    - Large intestine, right
    - Large intestine, left
    - Cecum
    - Ascending colon
    - Transverse colon
    - Descending colon
    - Sigmoid colon
Infusions, Chemotherapy, and Vascular Access Procedures

- Infusions/transfusions
  - Route of administration (artery or vein, peripheral or central vein)
  - Blood (specific blood and blood products)
  - Other substances (e.g., antineoplastic, destructive agent, thrombolytics, platelet inhibitor, etc.)
- Vascular access devices (e.g., PICC line insertions)
  - The correct coding of venous catheters depends on the end placement of the catheter, meaning the site where the device ended up (Coding Clinic, Third Quarter 2013, p. 18)

Angiography

- Type
  - Plain or fluoroscopy
- Body part
  - Coronary artery, single
  - Coronary arteries, multiple
  - Coronary artery bypass graft, single
  - Coronary artery bypass graft, multiple
- Contrast
  - High osmolar
  - Low osmolar
  - Other contrast
Imaging and Nuclear Medicine

• Contrast medium on imaging procedures
  – Low osmolar or high osmolar contrast
• Nuclear medicine
  – Radionuclide (e.g. Tc99m, Thallium 201, Iodine 123, Iodine 131)

Radiation Therapy, Brachytherapy, Stereotactic Radiosurgery

• Treatment site
• Modality qualifier
• Isotope (brachytherapy, e.g., Cesium 137)
Addressing Questions to the Central Office

Please be sure to read the FAQ section to find out what types of questions we can or cannot answer.

Thank you. Questions?

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 workbook.