Coding of Complications: Past, Present, and Future

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Learning Objectives

• At the completion of this educational activity, the learner will be able to:
  – Explain problematic, ambiguous documentation and other factors that cause confusion for coders
  – Describe documentation that would not be considered a complication
  – Identify documentation that is a complication
  – Discuss education opportunities for coding, CDI, and physicians
Past

- Historically physicians documented “postoperative” ileus, atelectasis, etc., and coders coded them as postoperative complications, no questions asked
- Hematomas, lacerations, and retained foreign bodies occurring in or around surgery were also coded as complications, no questions asked
- Even though this was not the reason for coding these conditions, most “postop” complications counted as a CC

Coding Clinic (CC): Fourth Qtr 1993, pp. 41–42

Postop Hypertension

- Q: Is postop HTN a cardiac condition or vascular, and how should it be coded?
  
  - A: It is not really cardiac complication, but the closest possible match is to continue to use 997.1, cardiac complication, to describe postop HTN.

CC, 5th Issue 1993, pp. 6–7

Postop Hypertension

- Q: What is the code for “postop HTN”?
  
  - A: Coding of “postop” conditions is dependent on the documentation.
    - Query to determine if HTN was related to or was a complication of the procedure, if so, code 997.1 and specific HTN code.
    - If physician states HTN is NOT related to the operative episode or physician cannot determine, code HTN code only.
**Postop Hypertension**

- Hypertension after the operative procedure
  - If the physician documents HTN sometime after the OR procedure but does not state postop or complication, a code from 401-405 series would be assigned
- 2015 codebook: 997.91, complication affecting BS, HTN.

**Postop Fever Guidelines**

- Q: How is fever after surgery coded?
  - A:
    - No guidelines direct the coder as to when to code fever that occurs postop as a complication
    - A diagnosis should not be coded as a complication unless stated as such by the attending
    - Body temp variations occur normally following surgery and are expected and not considered complications
    - If only fever is documented, query to determine if it is a complication

**Q:** Patient admitted after outpatient sinus surgery with premature atrial contractions postop. What is PR-DX?

- A: 427.61, supraventricular beats.
  - Assign code 997.1, cardiac complications, only if physician states that the condition is a complication
CC, Third Quarter 2005, pp. 16–17

• Q: What is the code for postop fever? Does it have to be documented as a complication?

• A: Assign 998.89, other complication of procedures
  - Codebook index: Fever
    postoperative 998.89
  - However, if only fever is documented in the physician’s diagnostic statement, query to determine if complication
  - 2015 codebook: Fever postop 780.62
due to infection 998.59

Guidance Related to Complications Is Rather Ambiguous

• Some issues of Coding Clinic assume relationship.
• Some state to query for clarification.
• The codebook index in some instance requires linkage.
• How does a coder know which guidance to follow?

In an Attempt to Identify Complications, the Next Popular Method Was ...

• To clarify the intent of the physician’s use of the term “postoperative” with a diagnosis
  - Was it merely reflecting the time frame?
  - Was it linking the condition to the procedure, implying a complication?
• The end result of this questioning was confusion and frustration for physicians because their definition of complication is not consistent with coding conventions
Postop Diagnoses That Are by Description
Assumed Complications

- Postop wound dehiscence
- Postop wound infection
- Infection due to device, implant, graft
- Erosion of device
- Fracture of hip replacement
- Malfunction of device, implant, or graft
- Displacement of device, implant, or graft
- Nonhealing amputation stump
- Rejection of transplant

Complications: Present & Future

Both ICD-9-CM and ICD-10 rules state:

- Code assignment is based on the provider’s documentation between the condition and the care or procedure
- The guideline extends to any complication of care, regardless of the chapter the code is located in
- It is important to note that not all conditions that occur during or following medical care or surgery are classified as complications

Complications: Present & Future

- There must be a cause-and-effect relationship between the care provided and the condition, and an indication in the documentation that it is a complication
- Query the provider if the complication is not clearly documented
Reminder: Criteria for Reporting “Other Diagnoses”

• Clinical evaluation; or
• Therapeutic treatment; or
• Diagnostic procedures; or
• Extended length of stay; or
• Increased nursing care or monitoring

Examples of Postop Diagnoses That Sometimes Cause Confusion

• Diabetic patient with insulin pump admitted in ketoacidosis
• Atrial fibrillation following procedure
• “Mild” hematoma after heart cath resolved with compression
• Ileus following GI surgery
• “Retained” foreign bodies
• Laceration/tear during surgery

Issue: Failure to “Recognize” a Cause-and-Effect Relationship

• Example:
  – Diabetic patient that has an insulin pump admitted with diabetic ketoacidosis
  – Physician documentation focused on treatment to resolve the ketoacidosis
  – Coder did not recognize that malfunction of insulin pump caused the ketoacidosis as a complication

CC, Fourth Quarter 2003, pp. 81–82
Postoperative Atrial Fibrillation

Q: We have been assigning 997.1 for postop atrial fibr since the code is specifically indexed under “fibrillation” “postop”.

A surgeon says that arrhythmia after a CABG or valve replacement procedure should not be considered a complication. How should this be coded?

A: Postop atrial fib codes to 997.1, cardiac complications, based on index in the codebook.

Hematoma Following Heart Cath

Progress notes state:
- “Mild” hematoma following heart cath
- The nurse applied pressure and the hematoma resolved

This was coded as a postop complication

Do you agree?
Is this clinically significant?

Postop Hemorrhage/Hematoma

Q: Concern about inconsistency in coding
- Ex: A surgical wound is slightly oozing blood and is treated with pressure
- Ex: A small hematoma after surgery but not treated

A: Code assignment is based on
- Provider’s documentation of the relationship between the condition and the procedure
- Meeting criteria of “other dx”
- Cause-and-effect relationship
- Coder cannot determine whether something that occurred during surgery is a complication or expected outcome
Control of Intraop Bleeding

Q: Patient has lap cholecystectomy
   – A small amount of bleeding in the liver bed had to be controlled.
   – A greater amount of bleeding was identified in the omentum.
   – Another port was placed to identify site of bleeding, additional time cauterizing and clipping to control oozing from the omentum.
   – ICD-10 root op “control” refers to stopping or attempting to stop post-procedure bleeding. Since this is intraop bleeding, rather than postop, how should this be coded?

A: Control of the small amount of bleeding from the liver bed is integral to the procedure and should not be coded separately
   • Although control of bleeding from the omentum required additional time and effort it is inherent to the procedure and should not be coded separately

Example

DX: Patient has multiple stab wounds to posterior thorax.
   – Lacerated bleeding intercostal artery of the L & R hemithorax. Blood loss 1000 mL.
   – A thoracotomy was performed and a rib spreader was inserted and a moderate amount of clot removed from the left chest.
   – We identified a bleeding intercostal artery; this was oversewn.
   – A small laceration to the lung was repaired with 3-0 chromic sutures. No other injuries noted.
   – This was coded as a hemorrhage complicating a procedure.
   • Do you agree?
CC, First Quarter 2012, pp. 6–7
Postoperative Ileus

• Q: One week ago the patient had lysis of adhesions for SBO and was admitted for treatment of an ileus with vomiting. How is this coded?

• A: PR-DX: 997.49, digestive system complication due to Alphabetic Index.
  – Ileus
    • Following gastrointestinal surgery 997.49
    • A causal relationship between surgery and the condition does not apply due to index in codebook

Scenario: General Surgeon Performs GI Surgeries

• General surgeon performs GI surgeries
• His progress notes consistently state ileus starting on postop day 1, 2, etc.
  – The diet progresses normally
  – No abdominal distension, vomiting, nausea, obstipation, or abdominal cramping
  – Bowel sounds are normal
  – No NG tube is inserted
  – Abdominal x-rays are not ordered

• Is this a complication? Should a code be assigned?

CDI and Coding Ileus Education Opportunity

• If the ileus following abdominal surgery is “expected” and is NOT symptomatic (beyond what is “normal” for the surgical procedure), a code should not be assigned

• If the patient is experiencing symptoms (nausea, vomiting, abdominal pain or distention) and the “normal” postop course is altered (i.e., diet progression, insertion of NG tube) the ileus should be coded as postop digestive complication
**Retained Foreign Body**

**Sponge**
CC, First Quarter 2009, p. 18  
CC, First Quarter 2012, pp. 12–13

**Needle/drill bit**
CC, First Quarter 2011, p. 5  
CC, Fourth Quarter 2013, pp. 90–91  
CC, First Quarter 2014, p. 21

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**Foreign Body Left During Surgery**

- Patient had gyn surgical procedures; incision was closed, x-ray was performed revealing a sponge, vaginal cuff reopened with sponge retrieval. How is this coded?

- Foreign body accidentally left during procedure.
  - Supported by National Quality Forum (NQF) directive that unintended retention of foreign object after surgery or other procedure should be reported
  - Unintended retention of objects at any point after the surgery ends should be captured regardless of setting or whether object is removed

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**Retained Sponge Following Vaginal Delivery**

- Q: Two days after vaginal delivery, patient expels sponge while voiding. Since the vagina is not a closed cavity, is this a retained foreign body?

- A: Yes, 998.4, foreign body accidentally left during surgery, is supported by NQF since this is unintended retention of objects at any point after surgery.
Broken Needle Left During Surgery

- During a procedure a needle broke and was lost in tissue. Attempts to retrieve unsuccessful. X-ray did not reveal needle. Patient closed.
- Second X-ray revealed location, patient reopened but needle could not be retrieved. The surgeon decided that continuing to look could cause more harm than good. Chest closed.
- Q: Provider intentionally left foreign body due to risk of continued search. Would this be coded as foreign body accidentally left during procedure?

- A: Assign 998.4, foreign body accidentally left during a procedure

- Even though the physician made the decision to leave the needle, it was not the intent of the original procedure to leave a foreign body behind

Dislodged Needle During Surgery

- During a procedure a needle became dislodged from needle driver. Attempts to retrieve unsuccessful, intraop scan could not locate. Lap procedure converted to open and needle was retrieved. Physician identified this as a complication. Should a foreign body code be assigned?

- The needle was retrieved before surgery ended; this was not a foreign body accidentally left. Code 998.89, other complication of procedure, since stated as a complication.
• A drill bit broke off deep inside the trochanter during a procedure and was not retrievable.

• The NQF revised info on serious reportable events states a unintended retention of foreign object after surgery or other invasive procedure excludes a foreign object that is not present prior to surgery but is intentionally left in when the risk of removal exceeds the risk of retention.

• Q: How is this coded?

• A: Do not assign 998.4 when provider intentionally leaves a foreign body during surgery due to the risks related to the removal.

• Assign E871.0, foreign object left in body during surgical operation, to show that there was a problem with a foreign object.

• Unfortunately E871.0 also triggers PSI #21, Foreign Body Accidentally Left During Surgery.

• Retained foreign objects:
  – Unintended retention of a foreign object in a patient after surgery or other invasive procedure
  – Additional specifications: Includes medical or surgical items intentionally placed by provider(s) that are unintentionally left in place
NQF: Retained Foreign Objects: Exclusions

• Objects present prior to surgery or other invasive procedure that are intentionally left in place
• Objects intentionally implanted as part of a planned intervention
• Objects not present prior to surgery/procedure that are intentionally left in when the risk of removal exceeds risk of retention (such as microneedles, broken screws)

NQF: Serious Reportable Events: Appendix B

• The surgery officially ends:
  – After all incisions or procedural access routes have been closed in their entirety, and
  – Device(s) such as probes or instruments have been removed, and
  – If relevant final surgical counts confirming accuracy and resolving any discrepancies have concluded, and
  – The patient has been taken from the operating/procedure room

CC, Third Quarter 1990, p. 18
Tear During Surgery

• Q: Should these scenarios be coded as accidental puncture or laceration?
  – Small tear of liver during retraction, controlled with hemopad
  – Lysis of multiple adhesions with duodenal serosal tears post lysis
• A: The surgeon should be queried to determine whether the physician considers the tear to be:
  – Incidental occurrence inherent in the surgical procedure
  – A complication of the procedure
Intraoperative Serosal Tears

Q: Should these scenarios be coded as accidental puncture or laceration?
- This patient had a retroperitoneal cystic mass that had adhered at the gastroesophageal junction
- A small capsular injury of the spleen, which was hemostatic
- A serosal injury to the stomach, repaired with sutures

A: Query the provider to determine whether the tear:
- Is clinically insignificant
  - If the provider states the tear is not clinically significant, omit codes for both the diagnosis and the procedure
- Is an incidental occurrence inherent to the surgical procedure
- Or is a complication

Where Do You Start?

Universal education related to documentation and the coding implications as related to complications
Where Do You Start With Medical Staff?

- Earn trust
- Make it clear that you are not trying to hide complications
- Nor are you trying to trick a physician into calling something a complication when he or she feels that it is not one
- Be honest regarding codebook directions on conditions that are assumed to be complications

Educate Providers on Documentation Needs
MD (Attendings), PAs, NPs, Residents

- Start with Coding Clinic verbiage related to complications:
  - Clinically insignificant
  - Incidental occurrence
    - Inherent to procedure
    - Inherent to the disease process
    - Due to anesthesia

Other Documentation Tips

- Use of expected (i.e., expected blood loss, pain, ileus)
- A complete description of circumstances that identify abnormal, complicating factors that reflect an incidental occurrence inherent to the procedure
  - Friable tissue that causes a tear
  - Dense adhesions complicating the procedure
  - Congenital anomalies
  - Morbid obesity
  - Cancer (entangled blood vessels, ureter, etc.)
Or Is It a Complication?

• Coding Clinic states that the physician must state that the condition is a complication.
• Many physicians do not like using the word “complication”; in those instances, the physician can state iatrogenic, “due to” or “related to” the procedure.
• Example: Through and through laceration of colon due to trocar placement.

Pt Had Hysterectomy; BSO; Extensive Lysis of Adhesions; Repair Enterotomy

• Patient counseled regarding high risk of bowel injury due to previous bowel surgery.
• Multiple dense adhesions of the small bowel to the anterior fascia, a small incidental enterotomy occurred secondary to the adhesions that was unavoidable. Dissection of the bowel off of the anterior abdominal wall took 1 hour, and once the small bowel was mobilized a segment was resected.
• Is this a complication?

CDI Education Opportunities

• Review these Coding Clinic issues with staff.
• Identify documentation opportunities when reviewing surgery records; query to clarify potential complications, expected conditions, or incidental occurrences (blood loss versus hemorrhage complication).
• Educate physicians to make sure they understand that ambiguous documentation can lead to coding of complications.
• Develop internal guidelines regarding expected blood loss for procedures.
Coder Education Opportunities

• Coders should:
  – Review Coding Clinic issues (especially new ones)
  – Review CDI concurrent queries and look for physician response
  – Query when not clear
  – Develop guidelines, educational tools
  – Educate new hires and contract coders to ensure compliance

Thank you. Questions?

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