CDI-Pertinent Coding Clinic Updates

James S. Kennedy, MD, CCDS, CDIP
President
CDIMD – Physician Champions
Smyrna, TN
Presenter

James S. Kennedy, MD, CDIP
President – CDIMD (near Nashville, TN)
Credentials:
• Internal medicine – the University of Tennessee
• ACDIS CCDS
• AHIMA CDIP – 2012
Contact:
• jkennedy@cdimd.com (615) 479-7021
Objectives

• At the completion of this educational activity, the learner will be able to:
  – Provide an overview on the 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-CM/PCS
Specific Topics Covered

• Authority of *Coding Clinic* with respect to the Index, Table, and Guidelines
  – What to do if the term suggested by the Index does not match the patient’s clinical indicators
• “With” and “In” diagnoses with special emphasis on Not Elsewhere Classified conditions
• Body mass index (BMI) with overweight, obesity, and morbid obesity
  – Discussion of exceptions with pediatric and obstetric patients
• Lobar pneumonia
• Spine surgery (if we have time)
Foundations
The AHA Central Office
Publisher of the *Coding Clinic for ICD-10-CM/PCS*

• 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-10-CM/PCS

• The AHA Central Office is the publisher of *AHA Coding Clinic for ICD-10-CM and ICD-10-PCS* and *AHA Coding Clinic for HCPCS*
  – *AHA Coding Clinic for ICD-10-CM and ICD-10-PCS* represents a formal cooperative effort between the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), the Centers for Disease Control and Prevention (CDC), the National Center for Health Statistics (NCHS), and the Centers for Medicare & Medicaid Services (CMS)
  • No advice is published without the consent of all the Cooperating Parties
Coding Clinic’s Authority
Endorsed by AHIMA and ACDIS

• Coding (and CDI) professionals should abide by the AHIMA (and ACDIS) Standards of Ethical Coding
  – Among several standards (e.g., ACDIS), the AHIMA standards specify that “Coding professionals shall adhere to the ICD coding conventions, official coding and reporting guidelines approved by the Cooperating Parties, the CPT rules established by the American Medical Association, and any other official coding rules and guidelines established for use with mandated standard code sets.”

• Advising coders to disregard Coding Clinic because of differences in understanding or personal interpretation may be construed as an ethical issue

Coding Clinic, Fourth Quarter 2018, p. 91
AHIMA Ethical Coding Standards – http://library.ahima.org/CodingStandards
Obtaining Coding Clinic Advice

Subscribing

• Subscriptions available:
  – Electronic access
    • ~$300/year
  – On many encoders (e.g., 3M, TruCode, Optum, Nuance)
    • Unfortunately often delayed by 30 or so days after the effective date

AHA
Coding Clinic®
for ICD-10-CM
A quarterly publication of the
Central Office on ICD-10-CM/PCS

You can get your own subscription at:
www.codingclinicadvisor.com
Send Your Own Questions to Coding Clinic Advisor

Anyone can send in questions and do it online
  – It is always best to submit a representative medical record outlining your problem, or else they will refuse to answer the question

www.codingclinicadvisor.com – It’s FREE!
Fundamentals of ICD-10-CM/PCS
ICD-10-CM Index to Diseases

1. ICD-10-CM Index to Diseases
   • The term must be looked up here first

2. ICD-10-CM Table of Diseases
   – Offers additional instructions, such as “code first,” “code in addition,” “in diseases classified elsewhere,” “Excludes1,” “Excludes2,” and others

3. ICD-10-CM Official Guidelines for Coding and Reporting
   – May add or subtract codes, influence sequencing, or provide instruction

4. Advice from Coding Clinic for ICD-10-CM/PCS
   – Fills the gaps not otherwise outlined in the Index, Table, or Guidelines

5. Court opinions or other payer-specific regulations
What Happens When *Coding Clinic* Advice Conflicts With the ICD-10-CM/PCS Conventions or the Guidelines?

• **Question:** When advice published in *Coding Clinic* conflicts with the *Official Guidelines for Coding and Reporting* or the ICD-10-CM/PCS classification, should coding professionals still follow the published advice or adhere to the instructions in the guidelines and/or the classification?

• **Answer:** Despite the efforts of the Cooperating Parties to ensure the accuracy of *Coding Clinic* advice, “coding professionals should adhere to the following hierarchy:
  – Conventions in the ICD-10-CM and ICD-10-PCS classification take precedence over the *Official Guidelines for Coding and Reporting*, and
  – Both the classification and guidelines take precedence over *Coding Clinic* advice.”

*Coding Clinic*, 4th Quarter 2018, pp. 90–91
ICD-10-CM Guidelines
Locating a Code in ICD-10-CM

• To select a code in the classification that corresponds to a diagnosis or reason for visit documented in a medical record, **first locate the term in the Alphabetic Index**, and then verify the code in the Tabular List

• Read and be guided by instructional notations that appear in both the Alphabetic Index and the Tabular List
Emaciation

ICD-10-CM Index and Table – Notice (Due to Malnutrition)

If a physician documents “emaciation”, it is first referenced in the Index
• Note that “due to malnutrition” is a non-essential modifier

Consequently, E41, Nutritional marasmus should be coded when the term “emaciation” is documented by the physician
ICD-10-CM Guidelines
Nonessential Modifiers

• Parentheses are used in both the Alphabetic Index and Tabular List to enclose supplementary words that may be present or absent in the statement of a disease or procedure without affecting the code number to which it is assigned
  – The terms within the parentheses are referred to as nonessential modifiers
  – The nonessential modifiers in the Alphabetic Index to Diseases apply to subterms following a main term except when a nonessential modifier and a subentry are mutually exclusive, the subentry takes precedence

Enteritis (acute) (diarrheal) (hemorrhagic) (noninfective) K52.9
- adenovirus A08.2
- aertrycke infection A02.0
- allergic K52.29
- chronic (noninfectious) K52.9
- ulcerative -see Colitis, ulcerative
Assign code R64, Cachexia, for a diagnosis of emaciated/emaciation.

- If the provider intended to describe malnutrition, then it should be documented as such.
- Although the Index currently refers to code E41, *a basic rule of coding is that further research is done if the title of the code suggested by the Index does not identify the condition correctly*.

Note that *Coding Clinic* doesn’t tell us exactly how to perform this additional research.

- Since coding is based only on provider documentation, any “further research” revolves around documentation of the provider’s clinical intent as to be coded.
- *Coding Clinic*, Fourth Quarter 2018 states that they have previously published advice on this topic, and that advice does not conflict with conventions in the classification nor the guidelines.
Extremely Important in Coding Compliance

Hospitals Billing for Severe Malnutrition on Medicare Claims

Many elderly Medicare patients, especially those who are severely ill, are malnourished. Malnutrition can result from the treatment of another condition, inadequate treatment or neglect, or the general deterioration of a patient’s health. Medicare sets forth a number of Federal requirements, including the Social Security Act § 1862(a)(1)(A), related to billing for the treatment of severe malnutrition. Hospitals are allowed to bill for the treatment of malnutrition on the basis of the severity of the condition - mild, moderate, or severe, and whether it affects patient care. Severe malnutrition is classified as a major complication or comorbidity (MCC). Adding an MCC to a Medicare claim can result in a higher Medicare payment because the claim is coded at a higher Diagnosis Related Group. This review will assess the accuracy of Medicare payments for the treatment of severe malnutrition. We will determine whether providers are complying with Medicare billing requirements when assigning diagnosis codes for the treatment of severe types of malnutrition on inpatient hospital claims.

What Happens When *Coding Clinic* Advice Conflicts With the ICD-10-CM/PCS Conventions or the Guidelines?

- The advice published in *Coding Clinic* is not intended to replace the instructions in the classification nor the *Official Guidelines for Coding and Reporting*. The advice is meant to be used when the ICD-10-CM/PCS classification and the guidelines do not provide direction.
  - For example, when the index is confusing, and leads to an inappropriate code, a basic rule is that further research is required if the title of the code suggested by the index clearly does not identify the condition correctly.
  - *Coding Clinic* has previously published advice on this topic, and that advice does not conflict with conventions in the classification nor the guidelines.
- If coding professionals feel that published advice is in conflict with coding guidelines or the ICD-10-CM/PCS classification, please submit a specific case example to the AHA Central Office, with potential for submission to the *Coding Clinic* Editorial Advisory Board for review.

*Coding Clinic*, Fourth Quarter 2018, pp. 90–91
What Does a Facility Do if a Physician Documents a Condition That Doesn’t Meet Criteria?

- **Question:** *Coding Clinic*, Fourth Quarter 2016, p. 149, states “A facility may require that a physician use a particular clinical definition or set of criteria when establishing a diagnosis.” Would it be appropriate for facilities to develop a policy to omit a diagnosis code based on the provider’s documentation not meeting established criteria?
What Does a Facility Do if a Physician Documents a Condition That Doesn’t Meet Criteria?

- **No.** It is not appropriate to develop internal policies to omit codes automatically when the documentation does not meet a particular clinical definition or diagnostic criteria.
  - Facilities may review documentation to clinically validate diagnoses and develop policies for querying the provider for clarification to confirm a diagnosis that may not meet particular criteria.
  - Facilities should also work with their medical staff to ensure conditions are appropriately diagnosed and documented.

- If after querying, the attending physician affirms that a patient has a particular condition in spite of certain clinical parameters not being met, the facility should request the physician document the clinical rationale and be prepared to defend the condition if challenged in an audit.

- **The facility should assign the appropriate code(s) for the conditions documented.**

*Coding Clinic, Fourth Quarter 2017, p. 110*
So, What Now?  
How to Handle “Emaciation” w/o Documented Malnutrition

• Option 1 – Just don’t code a condition that doesn’t meet the criteria for marasmus
  – The OIG and RACs do it ... why not us?
  – “No. It is not appropriate to develop internal policies to omit codes automatically when the documentation does not meet a particular clinical definition or diagnostic criteria.”*

• Option 2 – Query, query, query
  – “Facilities should also work with their medical staff to ensure conditions are appropriately diagnosed and documented.
  – If after querying, the attending physician affirms that a patient has a particular condition in spite of certain clinical parameters not being met, the facility should request the physician document the clinical rationale and be prepared to defend the condition if challenged in an audit. The facility should assign the appropriate code(s) for the conditions documented.”*

* Coding Clinic, Fourth Quarter 2017, p. 110
Underlying Rhythm w/Pacemakers/AICDs/CRT
Question: How does one code SSS in the presence of a pacemaker?

Answer: Although it can be argued that sick sinus syndrome (SSS) is an ongoing condition controlled by a pacemaker, no code assignment is required if no attention or treatment is provided to the condition or device.

- Differs from the ongoing medication administration provided for conditions such as congestive heart failure, hypertension, or diabetes mellitus, therefore justifying code assignment
SSS w/Cardiac Devices (Pacemaker, AICD, CRT-P, CRT-D)?

Coding Clinic, First Quarter 2019, pp. 33–34

• **Question:** How does one code SSS or other significant heart rhythm abnormality in the presence of a pacemaker?

• **Answer:** It is appropriate to code the specific condition and the presence of the cardiac device.
  – Although the pacemaker is controlling the heart rate, it does not cure SSS and the condition is still being managed/monitored

• **Official Guidelines for Coding and Reporting:** For reporting purposes, the definition for “other diagnoses” is interpreted as additional conditions that affect patient care in terms of requiring:
  – Clinical evaluation; or
  – Therapeutic treatment; or
  – Diagnostic procedures; or
  – Extended length of hospital stay; or
  – Increased nursing care and/or monitoring
## Risk-Adjustment Impact for Pacemakers

<table>
<thead>
<tr>
<th>FY2019 Code</th>
<th>Title</th>
<th>MS-DRG MCC/CC</th>
<th>SOI</th>
<th>ROM</th>
<th>2019 V23 HCC</th>
<th>2019 V23 Title</th>
<th>Aged RW</th>
<th>Aged FBDual</th>
<th>Inst Rw</th>
<th>Trumps</th>
<th>Trumped By</th>
</tr>
</thead>
<tbody>
<tr>
<td>I440</td>
<td>Atrioventricular block, first degree</td>
<td></td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I441</td>
<td>Atrioventricular block, second degree</td>
<td></td>
<td>2</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I442</td>
<td>Atrioventricular block, complete</td>
<td>CC</td>
<td>3</td>
<td>3</td>
<td>96</td>
<td>Specified Heart Arrhythmias</td>
<td>0.271</td>
<td>0.390</td>
<td>0.253</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>I4430</td>
<td>Unspecified atrioventricular block</td>
<td></td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I4439</td>
<td>Other atrioventricular block</td>
<td></td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I444</td>
<td>Left anterior fascicular block</td>
<td></td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I445</td>
<td>Left posterior fascicular block</td>
<td></td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I4460</td>
<td>Unspecified fascicular block</td>
<td></td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I4469</td>
<td>Other fascicular block</td>
<td></td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I447</td>
<td>Left bundle-branch block, unspecified</td>
<td></td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I450</td>
<td>Right fascicular block</td>
<td></td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I4510</td>
<td>Unspecified right bundle-branch block</td>
<td></td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I4519</td>
<td>Other right bundle-branch block</td>
<td></td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I452</td>
<td>Bifascicular block</td>
<td>CC</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I453</td>
<td>Trifascicular block</td>
<td>CC</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I454</td>
<td>Nonspecific intraventricular block</td>
<td></td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I455</td>
<td>Other specified heart block</td>
<td></td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I456</td>
<td>Pre-excitation syndrome</td>
<td></td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I4581</td>
<td>Long QT syndrome</td>
<td></td>
<td>2</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I4589</td>
<td>Other specified conduction disorders</td>
<td>CC</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I459</td>
<td>Conduction disorder, unspecified</td>
<td></td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Indications for AICD
Primary Prevention

- Inherited condition with high risk of ventricular tachycardia
- Prolonged Q-T syndrome w/ventricular tachycardia while on beta blockers
- Prolonged Q-T syndrome w/syncope while on beta blockers
- Short Q-T syndrome
- Brugada syndrome with one or more of the following:
  - Unexplained syncope or other transient loss of consciousness
  - Documented ventricular tachycardia
  - Family history of 1st or 2nd degree relative with sudden cardiac death due to Brugada or that is unexplained
- Idiopathic/primary ventricular fibrillation

- Hypertrophic cardiomyopathy with two or more of the following:
  - Family history of HCM-related SCD in at least one first-degree relative
  - At least one episode of unexplained syncope within the previous 12 months
  - Nonsustained ventricular tachycardia (3 or more PVCs) on ECG
  - Abnormal blood pressure (BP) response during upright exercise testing
  - Left ventricular (LV) wall thickness greater than or equal to 30 mm
  - Catecholamine polymorphic ventricular tachycardia
  - Idiopathic/primary ventricular tachycardia
Indications for AICD
Primary Prevention

- Ischemic dilated cardiomyopathy (defined as a reduced ejection fraction due to at least a 75% stenosis of one or more coronary artery or a previous myocardial infarction w/nonobstructive coronaries) AND BOTH
  - Myocardial infarction
  - Reduced left ventricular EF of ≤ 30%
    - Without heart failure
    - With heart failure

- Ischemic dilated cardiomyopathy for over 9 months AND ALL THREE OF THE FOLLOWING
  - Myocardial infarction* ≥ 3 months ago
  - Reduced left ventricular EF of ≤ 35%
  - Chronic heart failure after 3 months of guideline-directed medical therapy (GDMT) with NYHA Class 2 or 3 (not NYHA 4)
## Indications for Pacemakers/AICDs

<table>
<thead>
<tr>
<th>FY2019 Code</th>
<th>Title</th>
<th>MS-DRG</th>
<th>2019 V23</th>
<th>2019 V23 Title</th>
<th>Aged RW</th>
<th>Aged FBDual</th>
<th>Inst Rw</th>
<th>Trumps</th>
<th>Trumped By</th>
</tr>
</thead>
<tbody>
<tr>
<td>I420</td>
<td>Dilated cardiomyopathy</td>
<td>CC</td>
<td>85</td>
<td>Congestive Heart Failure</td>
<td>0.310</td>
<td>0.355</td>
<td>0.204</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>I421</td>
<td>Obstructive hypertrophic cardiomyopathy</td>
<td>CC</td>
<td>85</td>
<td>Congestive Heart Failure</td>
<td>0.310</td>
<td>0.355</td>
<td>0.204</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>I422</td>
<td>Other hypertrophic cardiomyopathy</td>
<td>CC</td>
<td>85</td>
<td>Congestive Heart Failure</td>
<td>0.310</td>
<td>0.355</td>
<td>0.204</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>I423</td>
<td>Endomyocardial (eosinophilic) disease</td>
<td>CC</td>
<td>85</td>
<td>Congestive Heart Failure</td>
<td>0.310</td>
<td>0.355</td>
<td>0.204</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>I425</td>
<td>Other restrictive cardiomyopathy</td>
<td>CC</td>
<td>85</td>
<td>Congestive Heart Failure</td>
<td>0.310</td>
<td>0.355</td>
<td>0.204</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>I428</td>
<td>Other cardiomyopathies</td>
<td>CC</td>
<td>85</td>
<td>Congestive Heart Failure</td>
<td>0.310</td>
<td>0.355</td>
<td>0.204</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>I429</td>
<td>Cardiomyopathy, unspecified</td>
<td>CC</td>
<td>85</td>
<td>Congestive Heart Failure</td>
<td>0.310</td>
<td>0.355</td>
<td>0.204</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>I43</td>
<td>Cardiomyopathy in diseases classified else</td>
<td>CC</td>
<td>85</td>
<td>Congestive Heart Failure</td>
<td>0.310</td>
<td>0.355</td>
<td>0.204</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>I255</td>
<td>Ischemic cardiomyopathy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Ischemic Dilated Cardiomyopathy

• **Question:** What is the correct ICD-9-CM code assignment when dilated and ischemic cardiomyopathy are both documented by the provider in the medical record?

• **Answer:** Assign code 414.8, Other specified forms of chronic ischemic heart disease, for dilated and ischemic cardiomyopathy. The underlying cause is the ischemic cardiomyopathy.

*Coding Clinic*, Fourth Quarter 2013, p. 102

No CC/MCC; APR-DRG SOI or ROM bump; HCC with I25.5, Ischemic cardiomyopathy
## Indications for Pacemakers/AICDs

<table>
<thead>
<tr>
<th>FY2019 Code</th>
<th>Title</th>
<th>MS-DRG MCC/CC</th>
<th>2019 V23 HCC</th>
<th>2019 V23 Title</th>
<th>Aged RW</th>
<th>Aged FBDual</th>
<th>Inst Rw</th>
<th>Trumps</th>
<th>Trumped By</th>
</tr>
</thead>
<tbody>
<tr>
<td>I442</td>
<td>Atrioventricular block, complete</td>
<td>CC</td>
<td>96</td>
<td>Specified Heart Arrhythmias</td>
<td>0.271</td>
<td>0.390</td>
<td>0.253</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>I452</td>
<td>Bifascicular block</td>
<td>CC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I453</td>
<td>Trifascicular block</td>
<td>CC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I4589</td>
<td>Other specified conduction disorders</td>
<td>CC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I462</td>
<td>Cardiac arrest due to underlying cardiac condition</td>
<td>MCC</td>
<td>84</td>
<td>Cardio-Respiratory Failure and Shock</td>
<td>0.314</td>
<td>0.517</td>
<td>0.313</td>
<td>None</td>
<td>82, 83</td>
</tr>
<tr>
<td>I468</td>
<td>Cardiac arrest due to other underlying condition</td>
<td>MCC</td>
<td>84</td>
<td>Cardio-Respiratory Failure and Shock</td>
<td>0.314</td>
<td>0.517</td>
<td>0.313</td>
<td>None</td>
<td>82, 83</td>
</tr>
<tr>
<td>I469</td>
<td>Cardiac arrest, cause unspecified</td>
<td>MCC</td>
<td>84</td>
<td>Cardio-Respiratory Failure and Shock</td>
<td>0.314</td>
<td>0.517</td>
<td>0.313</td>
<td>None</td>
<td>82, 83</td>
</tr>
<tr>
<td>I470</td>
<td>Re-entry ventricular arrhythmia</td>
<td>CC</td>
<td>96</td>
<td>Specified Heart Arrhythmias</td>
<td>0.271</td>
<td>0.390</td>
<td>0.253</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>I471</td>
<td>Supraventricular tachycardia</td>
<td>CC</td>
<td>96</td>
<td>Specified Heart Arrhythmias</td>
<td>0.271</td>
<td>0.390</td>
<td>0.253</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>I472</td>
<td>Ventricular tachycardia</td>
<td>CC</td>
<td>96</td>
<td>Specified Heart Arrhythmias</td>
<td>0.271</td>
<td>0.390</td>
<td>0.253</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>I479</td>
<td>Paroxysmal tachycardia, unspecified</td>
<td></td>
<td>96</td>
<td>Specified Heart Arrhythmias</td>
<td>0.271</td>
<td>0.390</td>
<td>0.253</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>I480</td>
<td>Paroxysmal atrial fibrillation</td>
<td></td>
<td>96</td>
<td>Specified Heart Arrhythmias</td>
<td>0.271</td>
<td>0.390</td>
<td>0.253</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>I481</td>
<td>Persistent atrial fibrillation</td>
<td>CC</td>
<td>96</td>
<td>Specified Heart Arrhythmias</td>
<td>0.271</td>
<td>0.390</td>
<td>0.253</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>I482</td>
<td>Chronic atrial fibrillation</td>
<td></td>
<td>96</td>
<td>Specified Heart Arrhythmias</td>
<td>0.271</td>
<td>0.390</td>
<td>0.253</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>I483</td>
<td>Typical atrial flutter</td>
<td>CC</td>
<td>96</td>
<td>Specified Heart Arrhythmias</td>
<td>0.271</td>
<td>0.390</td>
<td>0.253</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>I484</td>
<td>Atypical atrial flutter</td>
<td>CC</td>
<td>96</td>
<td>Specified Heart Arrhythmias</td>
<td>0.271</td>
<td>0.390</td>
<td>0.253</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>I4891</td>
<td>Unspecified atrial fibrillation</td>
<td></td>
<td>96</td>
<td>Specified Heart Arrhythmias</td>
<td>0.271</td>
<td>0.390</td>
<td>0.253</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>I4892</td>
<td>Unspecified atrial flutter</td>
<td>CC</td>
<td>96</td>
<td>Specified Heart Arrhythmias</td>
<td>0.271</td>
<td>0.390</td>
<td>0.253</td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>
## Indications for Pacemakers/AICDs/CRT

<table>
<thead>
<tr>
<th>FY2019 Code</th>
<th>Title</th>
<th>MS-DRG</th>
<th>2019 V23 Title</th>
<th>Aged RW</th>
<th>Aged FBDual</th>
<th>Inst Rw</th>
<th>Trumps</th>
<th>Trumped By</th>
</tr>
</thead>
<tbody>
<tr>
<td>I4901</td>
<td>Ventricular fibrillation</td>
<td>MCC</td>
<td>84 Cardio-Respiratory Failure and Shock</td>
<td>0.314</td>
<td>0.517</td>
<td>0.313</td>
<td>None</td>
<td>82, 83</td>
</tr>
<tr>
<td>I4902</td>
<td>Ventricular flutter</td>
<td>MCC</td>
<td>84 Cardio-Respiratory Failure and Shock</td>
<td>0.314</td>
<td>0.517</td>
<td>0.313</td>
<td>None</td>
<td>82, 83</td>
</tr>
<tr>
<td>I492</td>
<td>Junctional premature depolarization</td>
<td>CC</td>
<td>96 Specified Heart Arrhythmias</td>
<td>0.271</td>
<td>0.390</td>
<td>0.253</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>I495</td>
<td>Sick sinus syndrome</td>
<td>96</td>
<td>Specified Heart Arrhythmias</td>
<td>0.271</td>
<td>0.390</td>
<td>0.253</td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

**Others include:**
- Heart failure codes (I50.xx)
- Prolonged Q-T syndrome (not prolonged Q-T interval)
- Brugada syndrome (no specific code in ICD-10-CM – probably I45.89)
Acute Kidney Injury Due to Dehydration
Acute Kidney Injury
A Functional Disease of the Kidney

• AKI (which includes acute renal failure) is an abrupt decrease in kidney function defined as any of the following:
  – Increase in SCr by 0.3 mg/dl within 48 hours
  – Increase in SCr to 1.5 times baseline, which is known or presumed to have occurred within the prior 7 days
  – Urine volume < 0.5ml/kg/h for 6 hours

<table>
<thead>
<tr>
<th>Prerenal</th>
<th>Renal</th>
<th>Postrenal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypovolemia</td>
<td>Acute tubular necrosis</td>
<td>Obstructive uropathies</td>
</tr>
<tr>
<td>Low cardiac output</td>
<td>Acute glomerulonephritis</td>
<td>— Prostate enlargement</td>
</tr>
<tr>
<td>Shock-like states</td>
<td>Acute interstitial nephritis</td>
<td>— Ureteral kidney stone in a solitary kidney</td>
</tr>
<tr>
<td>(Bilateral) renal artery stenosis</td>
<td>“Cast nephropathy”</td>
<td>— Others</td>
</tr>
<tr>
<td>Renal vasoconstriction (e.g., contrast)</td>
<td>Vasculitis</td>
<td>Others</td>
</tr>
<tr>
<td>Others</td>
<td>Thrombotic angiopathy</td>
<td></td>
</tr>
</tbody>
</table>
Acute kidney failure and chronic kidney disease (N17-N19)

Excludes2: congenital renal failure (P96.0)
- drug- and heavy-metal-induced tubulo-interstitial and tubular conditions (N14.-)
- extrarenal uremia (R39.2)
- hemolytic-uremic syndrome (D59.3)
- hepatorenal syndrome (K76.7)
- postpartum hepatorenal syndrome (O90.4)
- posttraumatic renal failure (T79.5)
- prerenal uremia (R39.2)
- renal failure complicating abortion or ectopic or molar pregnancy (O00-O07, O08.4)
- renal failure following labor and delivery (O90.4)
- renal failure postprocedural (N99.0)

N17 Acute kidney failure

Code also associated underlying condition

Excludes1: posttraumatic renal failure (T79.5)

<table>
<thead>
<tr>
<th>N17.0 Acute kidney failure with tubular necrosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute tubular necrosis</td>
</tr>
<tr>
<td>Renal tubular necrosis</td>
</tr>
<tr>
<td>Tubular necrosis NOS</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>N17.1 Acute kidney failure with acute cortical necrosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute cortical necrosis</td>
</tr>
<tr>
<td>Cortical necrosis NOS</td>
</tr>
<tr>
<td>Renal cortical necrosis</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>N17.2 Acute kidney failure with medullary necrosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medullary [papillary] necrosis NOS</td>
</tr>
<tr>
<td>Acute medullary [papillary] necrosis</td>
</tr>
<tr>
<td>Renal medullary [papillary] necrosis</td>
</tr>
</tbody>
</table>

| N17.8 Other acute kidney failure                   |

<table>
<thead>
<tr>
<th>N17.9 Acute kidney failure, unspecified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute kidney injury (nontraumatic)</td>
</tr>
</tbody>
</table>

Excludes2: traumatic kidney injury (S37.0-)

- Notice that the ICD-10-CM Table for N17, Acute kidney failure, uses the “code also” note for the underlying condition and an Excludes1 for T79.5, Posttraumatic renal failure
  - “Code first” and “Use additional code” have sequencing implication
  - The “additional code” always follows and cannot be a principal diagnosis when the first code is reported
• **Question:** When a patient is admitted with acute renal failure (ARF) due to dehydration, but only IV hydration is performed and BUN and creatinine return to normal (no renal workup and no renal disease is noted), would the principal diagnosis change? Does the fact that renal workup was or was not done affect the sequencing?

• **Answer:** Assign code 584.9, Acute renal failure, unspecified, as the principal diagnosis. Acute renal failure was the reason for the admission. Code 276.5, Volume depletion, should be assigned as an additional diagnosis. The fact that renal function was not investigated or worked up does not affect code assignment.
New Advice

Coding Clinic, First Quarter 2019, p. 12

• **Question:** A patient is admitted after an episode of unresponsiveness secondary to syncope and urinary tract infection (UTI). The focus of treatment was directed at the syncope (CT of the head, cardiac workup, etc.).
  – During the admission, it is noted that the patient also had mild acute kidney injury (AKI) that was treated with intravenous hydration. The provider’s discharge diagnosis is syncope secondary to dehydration and AKI.
  – Should AKI always be sequenced as the principal diagnosis when a patient presents with an acute kidney injury and dehydration?

• **Answer:** The sequencing of dehydration and acute kidney injury (acute renal failure) should be based on the reason for the admission.
  – Query the physician regarding the principal reason that the patient was admitted, if the reason for the admission is not clearly documented.
  – There is no rule that acute kidney injury should always be sequenced first.
What Happens When *Coding Clinic* Advice Conflicts With the ICD-10-CM/PCS Conventions or the Guidelines?

- **Question:** When advice published in *Coding Clinic* conflicts with the *Official Guidelines for Coding and Reporting* or the ICD-10-CM/PCS classification, should coding professionals still follow the published advice or adhere to the instructions in the guidelines and/or the classification?

- **Answer:** Despite the efforts of the Cooperating Parties to ensure the accuracy of *Coding Clinic* advice, “coding professionals should adhere to the following hierarchy:
  
  - Conventions in the ICD-10-CM and ICD-10-PCS classification take precedence over the *Official Guidelines for Coding and Reporting*, and
  
  - Both the classification and guidelines take precedence over *Coding Clinic* advice.”

*Coding Clinic*, Fourth Quarter 2018, pp. 90–91
Takeaways

• Sequencing instructions in *Coding Clinic* are evolving
  – Just because *Coding Clinic* said something in the ICD-9-CM versions does not mean it still applies

• Principal diagnosis selection remains tricky
  – Should be what created medical necessity for the inpatient admission
  – Should correspond with the circumstances of admission followed by the diagnostic approach or treatment rendered
  – Must follow coding conventions involving the Index, Table, and Guidelines

• Payers will always dispute the PDx
Body Mass Index – Obesity
Morbid Obesity and BMI ≥ 40 Are HCCs
BMI of ≤ 19.9 or ≥ 40 Are MS-DRG CCs

**FY2019**

<table>
<thead>
<tr>
<th>Code</th>
<th>Title</th>
<th>MS-DRG</th>
<th>2019 V23</th>
<th>2019 V23 Title</th>
<th>Aged RW</th>
<th>Aged FB Dual</th>
<th>Inst Rw</th>
</tr>
</thead>
<tbody>
<tr>
<td>E6601</td>
<td>Morbid (severe) obesity due to excess calories</td>
<td>CC</td>
<td>22</td>
<td>Morbid Obesity</td>
<td>0.262</td>
<td>0.389</td>
<td>0.460</td>
</tr>
<tr>
<td>E6609</td>
<td>Other obesity due to excess calories</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E661</td>
<td>Drug-induced obesity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E662</td>
<td>Morbid (severe) obesity with alveolar hypoventilation</td>
<td>CC</td>
<td>22</td>
<td>Morbid Obesity</td>
<td>0.262</td>
<td>0.389</td>
<td>0.460</td>
</tr>
<tr>
<td>E663</td>
<td>Overweight</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E668</td>
<td>Other obesity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E669</td>
<td>Obesity, unspecified</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Z681</td>
<td>Body mass index (BMI) 19.9 or less, adult</td>
<td>CC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Z682</td>
<td>Body mass index (BMI) 20.0-20.9, adult</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Z6821</td>
<td>Body mass index (BMI) 21.0-21.9, adult</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Z6822</td>
<td>Body mass index (BMI) 22.0-22.9, adult</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Z6823</td>
<td>Body mass index (BMI) 23.0-23.9, adult</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Z6824</td>
<td>Body mass index (BMI) 24.0-24.9, adult</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Z6825</td>
<td>Body mass index (BMI) 25.0-25.9, adult</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Z6826</td>
<td>Body mass index (BMI) 26.0-26.9, adult</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**FY2019**

<table>
<thead>
<tr>
<th>Code</th>
<th>Title</th>
<th>MS-DRG</th>
<th>2019 V23</th>
<th>2019 V23 Title</th>
<th>Aged RW</th>
<th>Aged FB Dual</th>
<th>Inst Rw</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z6827</td>
<td>Body mass index (BMI) 27.0-27.9, adult</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Z6828</td>
<td>Body mass index (BMI) 28.0-28.9, adult</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Z6829</td>
<td>Body mass index (BMI) 29.0-29.9, adult</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Z6830</td>
<td>Body mass index (BMI) 30.0-30.9, adult</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Z6831</td>
<td>Body mass index (BMI) 31.0-31.9, adult</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Z6832</td>
<td>Body mass index (BMI) 32.0-32.9, adult</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Z6833</td>
<td>Body mass index (BMI) 33.0-33.9, adult</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Z6834</td>
<td>Body mass index (BMI) 34.0-34.9, adult</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Z6835</td>
<td>Body mass index (BMI) 35.0-35.9, adult</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Z6836</td>
<td>Body mass index (BMI) 36.0-36.9, adult</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Z6837</td>
<td>Body mass index (BMI) 37.0-37.9, adult</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Z6838</td>
<td>Body mass index (BMI) 38.0-38.9, adult</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Z6839</td>
<td>Body mass index (BMI) 39.0-39.9, adult</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Z6841</td>
<td>Body mass index (BMI) 40.0-44.9, adult</td>
<td>CC</td>
<td>22</td>
<td>Morbid Obesity</td>
<td>0.262</td>
<td>0.389</td>
<td>0.460</td>
</tr>
<tr>
<td>Z6842</td>
<td>Body mass index (BMI) 45.0-49.9, adult</td>
<td>CC</td>
<td>22</td>
<td>Morbid Obesity</td>
<td>0.262</td>
<td>0.389</td>
<td>0.460</td>
</tr>
<tr>
<td>Z6843</td>
<td>Body mass index (BMI) 50.0-59.9, adult</td>
<td>CC</td>
<td>22</td>
<td>Morbid Obesity</td>
<td>0.262</td>
<td>0.389</td>
<td>0.460</td>
</tr>
<tr>
<td>Z6844</td>
<td>Body mass index (BMI) 60.0-69.9, adult</td>
<td>CC</td>
<td>22</td>
<td>Morbid Obesity</td>
<td>0.262</td>
<td>0.389</td>
<td>0.460</td>
</tr>
<tr>
<td>Z6845</td>
<td>Body mass index (BMI) 70 or greater, adult</td>
<td>CC</td>
<td>22</td>
<td>Morbid Obesity</td>
<td>0.262</td>
<td>0.389</td>
<td>0.460</td>
</tr>
</tbody>
</table>

Morbid obesity and BMI ≥ 40 are APR-DRG SOI of 2
Other Impacts of Obesity/Morbid Obesity/BMI Codes

- **AHRQ Patient Safety Indicators**
  - AHRQ PSIs
    - *Obesity* and morbid obesity
    - *Underweight*
    - *BMI over 30*
  - CMS mortality and readmission measures
  - Others

<table>
<thead>
<tr>
<th>PARAMETER</th>
<th>LABEL</th>
<th>DF</th>
<th>ESTIMATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>TRANSFER</td>
<td>Transfer from an acute care facility</td>
<td>1</td>
<td>0.1505</td>
</tr>
<tr>
<td>ALCOHOL</td>
<td>Alcohol abuse</td>
<td>1</td>
<td>-0.2356</td>
</tr>
<tr>
<td>ANEMIODEF</td>
<td>Deficiency Anemias</td>
<td>1</td>
<td>-0.2431</td>
</tr>
<tr>
<td>BLDLOSS</td>
<td>Chronic blood loss anemia</td>
<td>1</td>
<td>-0.3348</td>
</tr>
<tr>
<td>CHF</td>
<td>Congestive heart failure</td>
<td>1</td>
<td>0.1867</td>
</tr>
<tr>
<td>CHRNLEUNG</td>
<td>Chronic pulmonary disease</td>
<td>1</td>
<td>-0.1564</td>
</tr>
<tr>
<td>COAG</td>
<td>Coagulopathy</td>
<td>1</td>
<td>0.4753</td>
</tr>
<tr>
<td>DEPRESS</td>
<td>Depression</td>
<td>1</td>
<td>-0.1919</td>
</tr>
<tr>
<td>DMCK</td>
<td>Diabetes w/ chronic complications</td>
<td>1</td>
<td>-0.2201</td>
</tr>
<tr>
<td>HTN_C</td>
<td>Hypertension</td>
<td>1</td>
<td>-0.2232</td>
</tr>
<tr>
<td>HYPOTHY</td>
<td>Hypothyroidism</td>
<td>1</td>
<td>-0.1793</td>
</tr>
<tr>
<td>LIVER</td>
<td>Liver disease</td>
<td>1</td>
<td>0.4274</td>
</tr>
<tr>
<td>LYTES</td>
<td>Fluid and electrolyte disorders</td>
<td>1</td>
<td>0.4595</td>
</tr>
<tr>
<td>METS</td>
<td>Metastatic cancer</td>
<td>1</td>
<td>0.5502</td>
</tr>
<tr>
<td>NEURO</td>
<td>Neurological disease</td>
<td>1</td>
<td>0.205</td>
</tr>
<tr>
<td>OBSESE</td>
<td>Obesity</td>
<td>1</td>
<td>-0.1999</td>
</tr>
<tr>
<td>PARA</td>
<td>Paralysis</td>
<td>1</td>
<td>-0.3217</td>
</tr>
<tr>
<td>PERIVASC</td>
<td>Peripheral vascular disease</td>
<td>1</td>
<td>0.1187</td>
</tr>
<tr>
<td>PSYCH</td>
<td>Psychoses</td>
<td>1</td>
<td>-0.3894</td>
</tr>
<tr>
<td>PULMIRC</td>
<td>Pulmonary circulation disease</td>
<td>1</td>
<td>0.1714</td>
</tr>
<tr>
<td>RENLFAIL</td>
<td>Renal failure</td>
<td>1</td>
<td>0.2235</td>
</tr>
<tr>
<td>TUMOR</td>
<td>Solid tumor w/ out metastasis</td>
<td>1</td>
<td>0.3313</td>
</tr>
<tr>
<td>WGTLOSS</td>
<td>Weight loss</td>
<td>1</td>
<td>0.0981</td>
</tr>
</tbody>
</table>
2019 ICD-10-CM Official Guidelines

• Code assignment is based on the documentation by patient’s provider (i.e. physician or other qualified healthcare practitioner legally accountable for establishing the patient’s diagnosis).
  – There are a few exceptions, such as codes for the Body Mass Index (BMI), depth of non-pressure chronic ulcers, pressure ulcer stage, coma scale, and NIH stroke scale (NIHSS) codes, code assignment may be based on medical record documentation from clinicians who are not the patient’s provider (i.e., physician or other qualified healthcare practitioner legally accountable for establishing the patient’s diagnosis), since this information is typically documented by other clinicians involved in the care of the patient (e.g., a dietitian often documents the BMI, a nurse often documents the pressure ulcer stages, and an emergency medical technician often documents the coma scale).
  – However, the associated diagnosis (such as overweight, obesity, acute stroke, or pressure ulcer) must be documented by the patient’s provider. If there is conflicting medical record documentation, either from the same clinician or different clinicians, the patient’s attending provider should be queried for clarification.
Definitions of Obesity and Morbid Obesity

- Obesity – “A multi-causal chronic disease recognized across the life-span resulting from long-term positive energy balance with development of excess adiposity that over time leads to structural abnormalities, physiological derangements, and functional impairments.
  - The disease of obesity increases the risk of developing other chronic diseases and is associated with premature mortality.
  - As with other chronic diseases, obesity is distinguished by multiple phenotypes, clinical presentations, and treatment responses.”

## Definitions of Weight-Related Diagnoses

<table>
<thead>
<tr>
<th>BMI (kg/m²)</th>
<th>Obesity Class</th>
<th>Disease Risk* (Relative to Normal Weight and Waist Circumference)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Underweight</strong></td>
<td>&lt; 18.5</td>
<td>-</td>
</tr>
<tr>
<td><strong>Normal</strong></td>
<td>18.5–24.9</td>
<td>-</td>
</tr>
<tr>
<td><strong>Overweight</strong></td>
<td>25.0–29.9</td>
<td>Increased</td>
</tr>
<tr>
<td><strong>Obesity</strong></td>
<td>30.0–34.9</td>
<td>I</td>
</tr>
<tr>
<td></td>
<td>35.0–39.9</td>
<td>II</td>
</tr>
<tr>
<td><strong>Extreme Obesity</strong></td>
<td>≥ 40</td>
<td>III</td>
</tr>
</tbody>
</table>

*Men ≤ 40 in (≤ 102 cm)  
Women ≤ 35 in (≤ 88 cm)  
> 40 in (> 102 cm)  
> 35 in (> 88 cm)  

NIH Definition Is Not the Only Definition

• **Question:** When the BMI is below 40, but morbid obesity is documented by the anesthesiologist (no other documentation regarding the patient’s obesity is recorded in the health record), is it appropriate to code morbid obesity or is a query recommended?

• **Answer:** Codes for overweight, obesity, or morbid obesity are assigned based on the provider’s documentation of these conditions.
  
  – **Therefore, if morbid obesity is documented, assign code E66.01, Morbid (severe) obesity due to excess calories.**
  
  – While the BMI is used as a screening tool for patients who are overweight or obese, there is no coding rule that defines what BMI values correspond to obesity or morbid obesity, since the conditions are coded only when diagnosed and documented by the provider or another physician involved in the patient’s care.

*Coding Clinic, Fourth Quarter 2018, pp. 79–80*
CMS National Coverage Determinations

Medical Necessity for Weight Loss Surgery
BMI ≥ 35 kg/m²

- Effective for services performed on and after June 27, 2012, Medicare Administrative Contractors (MACs) acting within their respective jurisdictions may determine coverage of stand-alone laparoscopic sleeve gastrectomy (LSG) for the treatment of co-morbid conditions related to obesity in Medicare beneficiaries only when all of the following conditions a.-c. are satisfied:
  a) The beneficiary has a body-mass index (BMI) ≥ 35 kg/m²,
  b) The beneficiary has at least one comorbidity related to obesity, and,
     • Noridian’s list is available at http://tinyurl.com/yyckvww8
  c) The beneficiary has been previously unsuccessful with medical treatment for obesity.
Morbid Obesity and Obesity vs. Overweight

- While obesity and morbid obesity are always clinically significant and reportable when documented by the provider, neither the code for overweight nor the BMI code is assigned if there is no documentation that the diagnosis of “overweight” meets the definition of a reportable secondary diagnosis.
  - Other diagnoses that also appear to be clinically significant include malnutrition, anorexia nervosa or other eating disorders, cachexia, abnormal weight loss/gain, and underweight.

*Coding Clinic, Fourth Quarter 2018, pp. 77–78; 82–83*
ICD-10-CM *Official Guidelines*

New for 2019

- Body mass index (BMI)
- As with all other secondary diagnosis codes, the BMI codes should only be assigned when the associated diagnosis (such as overweight or obesity) meets the definition of a reportable diagnosis (see Section III, Reporting Additional Diagnoses). **Do not assign BMI codes during pregnancy.**

- Loses potential CC or SOI bump
Pediatric BMI

- **BMI pediatric codes are for use for persons 2–20 years of age**
  - These percentiles are based on the growth charts published by the Centers for Disease Control and Prevention (CDC)

- **Z68.5 Body mass index (BMI) pediatric (as listed in the ICD-10-CM Index)**
  - Z68.51 Body mass index (BMI) pediatric, less than 5th percentile for age
  - Z68.52 Body mass index (BMI) pediatric, 5th percentile to less than 85th percentile for age
  - Z68.53 Body mass index (BMI) pediatric, 85th percentile to less than 95th percentile for age
  - Z68.54 Body mass index (BMI) pediatric, greater than or equal to 95th percentile for age

Documentation has to be in percentiles for age
Lobar Pneumonia
Lobar Pneumonia Is an HCC

<table>
<thead>
<tr>
<th>Code</th>
<th>Title</th>
<th>New</th>
<th>MS-DRG MCC/CC</th>
<th>2019 V23 HCC</th>
<th>2019 V23 Title</th>
<th>Aged RW</th>
<th>Aged FBDual</th>
<th>Inst Rw</th>
</tr>
</thead>
<tbody>
<tr>
<td>J153</td>
<td>Pneumonia due to streptococcus, group B</td>
<td>MCC</td>
<td>115</td>
<td></td>
<td>Pneumococcal Pneumonia, Empyema, Lung Abscess</td>
<td>0.164</td>
<td>0.286</td>
<td>0.160</td>
</tr>
<tr>
<td>J154</td>
<td>Pneumonia due to other streptococci</td>
<td>MCC</td>
<td>115</td>
<td></td>
<td>Pneumococcal Pneumonia, Empyema, Lung Abscess</td>
<td>0.164</td>
<td>0.286</td>
<td>0.160</td>
</tr>
<tr>
<td>J155</td>
<td>Pneumonia due to Escherichia coli</td>
<td>MCC</td>
<td>114</td>
<td></td>
<td>Aspiration and Specified Bacterial Pneumonias</td>
<td>0.612</td>
<td>0.732</td>
<td>0.160</td>
</tr>
<tr>
<td>J156</td>
<td>Pneumonia due to other Gram-negative bacteria</td>
<td>MCC</td>
<td>114</td>
<td></td>
<td>Aspiration and Specified Bacterial Pneumonias</td>
<td>0.612</td>
<td>0.732</td>
<td>0.160</td>
</tr>
<tr>
<td>J157</td>
<td>Pneumonia due to Mycoplasma pneumoniae</td>
<td>MCC</td>
<td>114</td>
<td></td>
<td>Aspiration and Specified Bacterial Pneumonias</td>
<td>0.612</td>
<td>0.732</td>
<td>0.160</td>
</tr>
<tr>
<td>J158</td>
<td>Pneumonia due to other specified bacteria</td>
<td>MCC</td>
<td>114</td>
<td></td>
<td>Aspiration and Specified Bacterial Pneumonias</td>
<td>0.612</td>
<td>0.732</td>
<td>0.160</td>
</tr>
<tr>
<td>J159</td>
<td>Unspecified bacterial pneumonia</td>
<td>MCC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>J160</td>
<td>Chlamydial pneumonia</td>
<td>MCC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>J168</td>
<td>Pneumonia due to other specified infectious organisms</td>
<td>MCC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>J17</td>
<td>Pneumonia in diseases classified elsewhere</td>
<td>MCC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>J180</td>
<td>Bronchopneumonia, unspecified organism</td>
<td>MCC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>J181</td>
<td>Lobar pneumonia, unspecified organism</td>
<td>MCC</td>
<td>115</td>
<td></td>
<td>Pneumococcal Pneumonia, Empyema, Lung Abscess</td>
<td>0.164</td>
<td>0.286</td>
<td>0.160</td>
</tr>
<tr>
<td>J182</td>
<td>Hyopstatic pneumonia, unspecified organisa</td>
<td>CC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>J188</td>
<td>Other pneumonia, unspecified organism</td>
<td>MCC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>J189</td>
<td>Pneumonia, unspecified organism</td>
<td>MCC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Lobar pneumonia is an HCC
Unspecified pneumonia is not an HCC
Lobar Pneumonia

- Acute pneumonia involving one or more lobes of the lung characterized by sudden onset, chill, fever, difficulty in breathing, cough, and blood-stained sputum, marked by consolidation, and normally followed by resolution and return to normal of the lung tissue

- Typically associated with pneumococcal pneumonia (which was how it was classified in ICD-9-CM)

ISSN 2002-4436. Creative Commons CC0 1.0 Universal Public Domain Dedication. Used with permission.
Lobar Pneumonia

**Question:** When the physician documents “Right upper lobe pneumonia” and the causal organism is not documented, would it be appropriate to assign code J18.1, Lobar pneumonia?

**Answer:** Yes. Assign code J18.1, Lobar pneumonia, unspecified organism, for right upper lobe pneumonia when the causal organism is not documented.

- If the specific organism causing the pneumonia is documented, assign a combination code indicating the specific pneumonia with the responsible organism. If the provider documents that the pneumonia is specific to a lobe, or a similar diagnostic statement for pneumonia affecting one or more lobes of the five lobes of the lung, or part of a lobe, code J18.1 would be assigned when the causal organism is not specified.

- A diagnosis of “lobar pneumonia” (pneumonia that mentions the affected lobe) or “multilobar pneumonia” (pneumonia affecting more than one lobe) describes the specific site of the pneumonia (rather than a type of pneumonia) and would be coded according to the responsible organism, if known.
Use of Imaging to Obtain Location

*Coding Clinic*, First Quarter 2014, p. 5

**Question:** Previous *Coding Clinic* advice has supported the assignment of a more specific fracture code in ICD-9-CM and ICD-10-CM based on findings in imaging reports when a physician has documented a diagnosis of fracture. Does this advice hold true for other conditions that may be further specified based on imaging reports?

– For example, if a patient is diagnosed with a cerebral infarction or hemorrhagic stroke, can the imaging results be used to identify the specific vessel associated with these conditions?

**Answer:** It is appropriate to utilize imaging reports to provide greater specificity of the anatomic site as documented by the physician. Therefore, if a patient is diagnosed with a cerebral infarction or hemorrhagic stroke, it would be appropriate to utilize the imaging report to determine the location of the stroke or infarction.
Radiology Reports w/Lobar Pneumonia

October 10, 2018

James Kennedy
CDIMD Physician Champions
110 Frances King Drive
Smyrna, TN 37167-5352

Dear Dr. Kennedy,

This letter is in response to your request for clarification regarding code assignment of lobar pneumonia from imaging reports. This issue requires referral to the Editorial Advisory Board (EAB) of Coding Clinic for review. Following resolution by the EAB, you will receive a definitive response. I trust this information will be of assistance to you.

Sincerely,

Diane Komar
Diane Komar, RHIT
Coding Consultant

Not answered in Coding Clinic, First Quarter 2019
“With” or “In”
Diverticulosis With Bleeding
ICD-10-CM Index

Diverticulosis K57.90
- with bleeding K57.91
- large intestine K57.30
- - with
  - - bleeding K57.31
  - - small intestine K57.50
    • - - - with bleeding K57.51
- small intestine K57.10
- - with
  - - bleeding K57.11
  - - large intestine K57.50
- - - - with bleeding K57.51

Notice the word “with”
FY 2019 ICD-10-CM Official Guidelines
“With” or “In”

• The word “with” or “in” should be interpreted to mean “associated with” or “due to” when it appears in a code title, the Alphabetic Index (either under a main term or subterm), or an instructional note in the Tabular List.
  – The classification presumes a causal relationship between the two conditions linked by these terms in the Alphabetic Index or Tabular List.
  – These conditions should be coded as related even in the absence of provider documentation explicitly linking them, unless the documentation clearly states the conditions are unrelated or when another guideline exists that specifically requires a documented linkage between two conditions (e.g., sepsis guideline for “acute organ dysfunction that is not clearly associated with the sepsis”).
**Angiodysplasia or Diverticulosis w/Bleeding**  
*Coding Clinic*, Third Quarter 2018, pp. 22–23

**Question**: A patient admitted with hematochezia underwent colonoscopy. The provider’s diagnostic impression included non-thrombosed and non-bleeding internal hemorrhoids, sigmoid diverticulosis, colonic angiodysplasia, and adenomatous cecum polyp.

**Answer**: Assign code K57.31, Diverticulosis of large intestine without perforation or abscess *with bleeding*, and code K55.21, Angiodysplasia of colon *with hemorrhage*, for the diverticulosis and colonic angiodysplasia with GI bleeding.

– Either condition may be sequenced as the principal diagnosis.
– The fact that bleeding is not seen during colonoscopy does not preclude the assignment of a code describing hemorrhage. ICD-10-CM makes a linkage between gastrointestinal hemorrhage and diverticulosis and angiodysplasia; therefore, the provider does not have to link the conditions in the documentation.
Many GI Terms in Index “With Bleeding”
Linkage by MD Not Required

**Gastritis (simple)** K29.70
- *with* bleeding K29.71
- acute (erosive) K29.00
- *with* bleeding K29.01
- alcoholic K29.20
- *with* bleeding K29.21
- allergic K29.60
- *with* bleeding K29.61
- atrophic (chronic) K29.40
- *with* bleeding K29.41

**Gastritis (simple)** K29.70
- chronic (antral) (fundal) K29.50
- *with* bleeding K29.51
- atrophic K29.40
  - *with* bleeding K29.41
- superficial K29.30
  - *with* bleeding K29.31
- dietary counseling and surveillance Z71.3
- due to diet deficiency E63.9
- eosinophilic K52.81
- giant hypertrophic K29.60
- *with* bleeding K29.61
Many GI Bleeds Are MCCs With Specified Pathologies

<table>
<thead>
<tr>
<th>Code</th>
<th>Diagnosis</th>
<th>MCC</th>
</tr>
</thead>
<tbody>
<tr>
<td>K2900</td>
<td>Acute gastritis without bleeding</td>
<td></td>
</tr>
<tr>
<td>K2901</td>
<td>Acute gastritis with bleeding</td>
<td>MCC</td>
</tr>
<tr>
<td>K2920</td>
<td>Alcoholic gastritis without bleeding</td>
<td></td>
</tr>
<tr>
<td>K2921</td>
<td>Alcoholic gastritis with bleeding</td>
<td>MCC</td>
</tr>
<tr>
<td>K2930</td>
<td>Chronic superficial gastritis without bleeding</td>
<td></td>
</tr>
<tr>
<td>K2931</td>
<td>Chronic superficial gastritis with bleeding</td>
<td>MCC</td>
</tr>
<tr>
<td>K2940</td>
<td>Chronic atrophic gastritis without bleeding</td>
<td></td>
</tr>
<tr>
<td>K2941</td>
<td>Chronic atrophic gastritis with bleeding</td>
<td>MCC</td>
</tr>
<tr>
<td>K2950</td>
<td>Unspecified chronic gastritis without bleeding</td>
<td></td>
</tr>
<tr>
<td>K2951</td>
<td>Unspecified chronic gastritis with bleeding</td>
<td>MCC</td>
</tr>
<tr>
<td>K2960</td>
<td>Other gastritis without bleeding</td>
<td>MCC</td>
</tr>
<tr>
<td>K2961</td>
<td>Other gastritis with bleeding</td>
<td>MCC</td>
</tr>
<tr>
<td>K2970</td>
<td>Gastritis, unspecified, without bleeding</td>
<td></td>
</tr>
<tr>
<td>K2971</td>
<td>Gastritis, unspecified, with bleeding</td>
<td>MCC</td>
</tr>
<tr>
<td>K2980</td>
<td>Duodenitis without bleeding</td>
<td></td>
</tr>
<tr>
<td>K2981</td>
<td>Duodenitis with bleeding</td>
<td>MCC</td>
</tr>
<tr>
<td>K2990</td>
<td>Gastroduodenitis, unspecified, without bleeding</td>
<td></td>
</tr>
<tr>
<td>K2991</td>
<td>Gastroduodenitis, unspecified, with bleeding</td>
<td>MCC</td>
</tr>
</tbody>
</table>
Other Common Automatic Linkages Not Requiring Query

Hypertension, hypertensive (accelerated) (benign) (essential) (idiopathic) (malignant) (systemic) I10
- with
  -- heart failure (congestive) I11.0
  -- heart involvement (conditions in I50.-, I51.4- I51.9 due to hypertension) - see Hypertension, heart
  -- kidney involvement - see Hypertension, kidney

Anemia (essential) (general) (hemoglobin deficiency) (infantile) (primary) (profound) D64.9
- in (due to) (with)
  -- chronic kidney disease D63.1
  -- end stage renal disease D63.1
  -- failure, kidney (renal) D63.1
  -- neoplastic disease - see also Neoplasm D63.0

Diabetes, diabetic (mellitus) (sugar) E11.9
- with
  -- amyotrophy E11.44
  -- arthropathy NEC E11.618
  -- autonomic (poly) neuropathy E11.43
  -- cataract E11.36
  -- Charcot's joints E11.610
  -- chronic kidney disease E11.22
  -- circulatory complication NEC E11.59
  -- complication E11.9

- Special attention must be paid to “NEC”
6. Abbreviations

a. Alphabetic Index abbreviations
   
   NEC  “Not elsewhere classifiable”
   This abbreviation in the Alphabetic Index represents “other specified.” When a specific code is not available for a condition, the Alphabetic Index directs the coder to the “other specified” code in the Tabular List.

   NOS  “Not otherwise specified”
   This abbreviation is the equivalent of unspecified.

b. Tabular List abbreviations
   
   NEC  “Not elsewhere classifiable”
   This abbreviation in the Tabular List represents “other specified”. When a specific code is not available for a condition, the Tabular List includes an NEC entry under a code to identify the code as the “other specified” code.

   NOS  “Not otherwise specified”
   This abbreviation is the equivalent of unspecified.
Diabetes
Index to Diseases

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

- - gastroparalysis E11.43
- - gastroparesis E11.43
- - glomerulonephrosis, intracapillary E11.21
- - glomerulosclerosis, intercapillary E11.21
- - hyperglycemia E11.65
- - hyperosmolarity E11.00
  - - - with coma E11.01
- - hypoglycemia E11.649
  - - - with coma E11.641
- - ketoacidosis E11.10
  - - - with coma E11.11
- - kidney complications NEC E11.29
- - Kimmelsteil-Wilson disease E11.21
- - loss of protective sensation (LOPS) -see Diabetes, by type, with neuropathy
Diabetes
Index to Diseases

- With
  - mononeuropathy E11.41
  - myasthenia E11.44
  - necrobiosis lipoidica E11.620
  - nephropathy E11.21
  - neuralgia E11.42
  - neurologic complication NEC E11.49
  - neuropathic arthropathy E11.610
  - neuropathy E11.40
  - ophthalmic complication NEC E11.39

Note how NEC designation is laced throughout the diabetes codes

- oral complication NEC E11.638
- osteomyelitis E11.69
- periodontal disease E11.630
- peripheral angiopathy E11.51
- with gangrene E11.52
- polyneuropathy E11.42
- renal complication NEC E11.29
- renal tubular degeneration E11.29
- skin complication NEC E11.628
- skin ulcer NEC E11.622
NEC in Association With “With” and “In”

Coding Clinic, Second Quarter 2018, p. 7

• The “with” guideline does not apply to “not elsewhere classified (NEC)” index entries that cover broad categories of conditions
  – Specific conditions must be linked by the terms “with,” “due to,” or “associated with”

• For example, arthropathy is a general term for any condition that affects the joints, and there are different types of arthropathic conditions that are not necessarily related to diabetes
  – In order to link diabetes and arthritis, the provider would need to document the condition as a diabetic complication
  – Coding professionals should not assume a causal relationship when the diabetic complication is “NEC”
Spine Surgery
# Spinal Fusion DRG w/MDC 8

<table>
<thead>
<tr>
<th>MS-DRG</th>
<th>FY 2019 FINAL Post-Acute DRG</th>
<th>MS-DRG Type</th>
<th>MDC</th>
<th>Type</th>
<th>MS-DRG Title</th>
<th>Weights</th>
<th>LOS</th>
<th>A LOS</th>
</tr>
</thead>
<tbody>
<tr>
<td>453</td>
<td>No</td>
<td>No</td>
<td>08</td>
<td>SURG</td>
<td>COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W MCC</td>
<td>9.4969</td>
<td>7.6</td>
<td>9.7</td>
</tr>
<tr>
<td>454</td>
<td>No</td>
<td>No</td>
<td>08</td>
<td>SURG</td>
<td>COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W CC</td>
<td>6.3368</td>
<td>4.0</td>
<td>4.7</td>
</tr>
<tr>
<td>455</td>
<td>No</td>
<td>No</td>
<td>08</td>
<td>SURG</td>
<td>COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W/O CC/MCC</td>
<td>5.0000</td>
<td>2.6</td>
<td>3.0</td>
</tr>
<tr>
<td>456</td>
<td>No</td>
<td>No</td>
<td>08</td>
<td>SURG</td>
<td>SPINAL FUS EXC CERV W SPINAL CURV/MALIG/INFEC OR EXT FUS W MCC</td>
<td>9.1252</td>
<td>9.5</td>
<td>11.6</td>
</tr>
<tr>
<td>457</td>
<td>No</td>
<td>No</td>
<td>08</td>
<td>SURG</td>
<td>SPINAL FUS EXC CERV W SPINAL CURV/MALIG/INFEC OR EXT FUS W CC</td>
<td>6.5446</td>
<td>5.3</td>
<td>6.1</td>
</tr>
<tr>
<td>458</td>
<td>No</td>
<td>No</td>
<td>08</td>
<td>SURG</td>
<td>SPINAL FUS EXC CERV W SPINAL CURV/MALIG/INFEC OR EXT FUS W/O CC/MCC</td>
<td>5.1212</td>
<td>3.2</td>
<td>3.6</td>
</tr>
<tr>
<td>459</td>
<td>Yes</td>
<td>No</td>
<td>08</td>
<td>SURG</td>
<td>SPINAL FUSION EXCEPT CERVICAL W MCC</td>
<td>6.3848</td>
<td>6.3</td>
<td>7.9</td>
</tr>
<tr>
<td>460</td>
<td>Yes</td>
<td>No</td>
<td>08</td>
<td>SURG</td>
<td>SPINAL FUSION EXCEPT CERVICAL W/O MCC</td>
<td>4.0375</td>
<td>2.9</td>
<td>3.4</td>
</tr>
<tr>
<td>471</td>
<td>No</td>
<td>No</td>
<td>08</td>
<td>SURG</td>
<td>CERVICAL SPINAL FUSION W MCC</td>
<td>5.0107</td>
<td>6.3</td>
<td>8.6</td>
</tr>
<tr>
<td>472</td>
<td>No</td>
<td>No</td>
<td>08</td>
<td>SURG</td>
<td>CERVICAL SPINAL FUSION W CC</td>
<td>2.9468</td>
<td>2.4</td>
<td>3.2</td>
</tr>
<tr>
<td>473</td>
<td>No</td>
<td>No</td>
<td>08</td>
<td>SURG</td>
<td>CERVICAL SPINAL FUSION W/O CC/MCC</td>
<td>2.3729</td>
<td>1.5</td>
<td>1.8</td>
</tr>
</tbody>
</table>

## Two spinal columns

## One spinal column (anterior or posterior)

## No Spinal Fusion

2019 Copyright, HCPro, a division of Simplify Compliance LLC, and/or session presenter(s). All rights reserved. These materials may not be copied without written permission.
Spinal Fusion (Except Cervical)
PDx – SDx – Procedure Considerations

MS-DRG | FY 2019 FINAL Post-Acute DRG | FY 2019 FINAL Special Pay DRG | MDC | TYPE | MS-DRG Title | Weights | GM LOS | A LOS
--- | --- | --- | --- | --- | --- | --- | --- | ---
456 | No | No | 08 | SURG | SPINAL FUS EXC CERV W SPINAL CURV/MALIG/INFEC OR EXT FUS W MCC | 9.1252 | 9.5 | 11.6
457 | No | No | 08 | SURG | SPINAL FUS EXC CERV W SPINAL CURV/MALIG/INFEC OR EXT FUS W CC | 6.5446 | 5.3 | 6.1
458 | No | No | 08 | SURG | SPINAL FUS EXC CERV W SPINAL CURV/MALIG/INFEC OR EXT FUS W/O CC/MCC | 5.1212 | 3.2 | 3.6
459 | Yes | No | 08 | SURG | SPINAL FUSION EXCEPT CERVICAL W MCC | 6.3848 | 6.3 | 7.9
460 | Yes | No | 08 | SURG | SPINAL FUSION EXCEPT CERVICAL W/O MCC | 4.0375 | 2.9 | 3.4

MS-DRG 456–458 requires either
- **Principal diagnosis of** an infection or neoplasm of the spine, kyphosis, lordosis, scoliosis, juvenile osteochondrosis or other deforming dorsopathies, collapsed vertebra, pathological (not traumatic) fracture of any cause (including osteoporosis), congenital deformity, or osteogenesis imperfecta - **OR** -

- **Secondary diagnosis of** any scoliosis - **OR** -
- **Extensive fusion (8 or more thoracic or >2 thoracic/>2 lumbar joints)**
Spinal Fusion (Except Cervical)
Scoliosis as a SDx

• A spinal curvature of more than 10° to the right or left as the examiner faces the person, i.e. in the coronal plane.
  – To qualify as an additional diagnosis grouping to MS-DRG 456–458, it must impact the diagnostic evaluation, treatment, length of stay, or nursing care as outlined in the ICD-10-CM Official Guidelines

• Can occur in adults due to spine degeneration or other causes
Degenerative Scoliosis

Coding Clinic, First Quarter 2019

• **Question:** Currently, ICD-10-CM does not have a specific code for degenerative scoliosis. What is the appropriate code assignment for degenerative scoliosis?

• **Answer:** Assign a code from subcategory M41.5-, Other secondary scoliosis, for degenerative scoliosis.

Impacts BPCI spinal fusion model, moving MS-DRG 459–460 to 456–458
Degenerative Scoliosis
M41.5-

Query needed if diagnosis is only on the radiology report

M41.5 Other secondary scoliosis
M41.50 Other secondary scoliosis, site unspecified
M41.52 Other secondary scoliosis, cervical region
M41.53 Other secondary scoliosis, cervicothoracic region
M41.54 Other secondary scoliosis, thoracic region
M41.55 Other secondary scoliosis, thoracolumbar region
M41.56 Other secondary scoliosis, lumbar region
M41.57 Other secondary scoliosis, lumbosacral region

Diagnostic Imaging Report

Findings:
A lumbosacral transitional segment is seen. There are five non rib-bearing lumbar type vertebrae seen superior to this segment. For the purposes of this report, this segment will be designated as S1. A 14.8 degree left convex scoliosis is seen from L1-L5 with the apex at L2. A grade 1 anterolisthesis of L4 on L5 is seen, with associated degenerative changes. There is no evidence of instability with flexion and extension.
The bone density is adequate. There is no evidence of fracture, dislocation or osseous destruction.
Moderate intervertebral disc space narrowing is seen from T12-L1 through L5-S1. Prominent spondylosis is seen at T12 and L1. Severe hypertrophy and sclerosis is seen at the facet joints from L2-L3 through L5-S1. The sacroiliac joints are maintained.
Conduit wall calcification is visualized anterior to the lumbar spine and in the pelvic soft tissues, without evidence of dilation.

Impressions:
1. Lumbosacral transitional segment, designated S1.
2. Moderate degenerative disc disease, T12-L1 through L5-S1.
4. Severe degenerative facet joint arthrosis, L2-L3 through L5-S1.
5. Grade 1 degenerative anterolisthesis, L4 on L5, without evidence of instability.
6. 14.8 degree left convex scoliosis from L1-L5 with the apex at L2.
7. Atherosclerotic calcification of the abdominal aorta and iliac arteries, without evidence of dilation.
ICD-10-CM Index to Diseases

Spinal Stenosis

Stenosis

• spinal M48.00
  – cervical region M48.02
  – cervicothoracic region M48.03
  – lumbar region (NOS) (without neurogenic claudication) M48.061
  • with neurogenic claudication M48.062
  – lumbosacral region M48.07
  – occipito-atlanto-axial region M48.01
  – sacrococcygeal region M48.08
  – thoracic region M48.04
  – thoracolumbar region M48.05

ICD-10-CM Index to Diseases

Spinal Stenosis

• Causes of spinal stenosis
  – Degenerative disc disease
  – Osteoarthritis (spondylosis)
  – Spondylolisthesis
  – Trauma
  – Tumors
  – Others
Spinal Stenosis w/Myelopathy

*Coding Clinic, Third Quarter 2018, p. 18*

• **Question:** What is the code assignment for stenosis of the cervical spine at C3-C6 with myelopathy?

• **Answer:** Assign BOTH codes:
  - M48.02, Spinal stenosis, cervical region, and
  - G99.2, Myelopathy in diseases classified elsewhere, for cervical spinal stenosis (C3-C6) with myelopathy.

Note that the documentation did not include the underlying cause of the spinal stenosis. For completeness, the physician should indicate the cause of the spinal stenosis.
> DRG Assignment w/Spinal Stenosis as PDx
> MS-DRG 519 With CC

<table>
<thead>
<tr>
<th>ICD-10 Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medicare DRG and MDC Information</strong></td>
</tr>
<tr>
<td>519</td>
</tr>
<tr>
<td>008</td>
</tr>
<tr>
<td><strong>APR (all versions) DRG and MDC Information</strong></td>
</tr>
<tr>
<td>310</td>
</tr>
<tr>
<td>008</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>1</td>
</tr>
</tbody>
</table>

- PDx – Spinal stenosis
- SDx – Myelopathy
- Procedure – release of the cervical spinal cord

Myelopathy is a CC in MS-DRGs and SOI 2 in APR
DRG Assignment w/Myelopathy as PDx
MS-DRG 520 Without CC

• PDx – Myelopathy
• SDx – Spinal stenosis
• Procedure – release of the cervical spinal cord

• Loss of MS-DRG CC with myelopathy as PDx
Spinal Stenosis w/ DDD and Myelopathy

Coding Clinic, Third Quarter 2018, p. 19

• **Question:** A patient presents with cervical spinal stenosis (C5-C6) and degenerative disc disease with myelopathy and radiculopathy that is surgically treated via laminectomy.
  – What is the code assignment for cervical spinal stenosis (C5-C6) and degenerative disc disease with myelopathy and radiculopathy (cord and nerve root compression)?

• **Answer:** In this case, it is appropriate to code the cervical spinal stenosis separately.
  – Assign code M48.02, Spinal stenosis, cervical region, for the spinal stenosis, which appeared to be the primary problem treated via laminectomy.
  – Codes M50.022, Cervical disc disorder at C5-C6 level with myelopathy, and M50.122, Cervical disc disorder at C5-C6 level with radiculopathy, should be assigned as additional diagnoses.
**Foraminal Stenosis**  
*Coding Clinic, Third Quarter 2018, pp. 20–21*

- **Question:** How is lumbar and lumbosacral foraminal stenosis of the lumbar spine coded?
- **Answer:** Assign codes M48.061, Spinal stenosis, lumbar region without neurogenic claudication, and M48.07, Spinal stenosis, lumbosacral region. Foraminal stenosis is a specific type of spinal stenosis.
Thank you. Questions?

jkennedy@cdimd.com

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 of the program guide.