ICD-10-CM/PCS Official Guidelines for Coding and Reporting: Review and Application

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Learning Objectives

- At the completion of this educational activity, the learner will be able to:
  - Apply specific ICD-10-CM and ICD-10-PCS coding guidelines
  - Discuss case examples applicable to ICD-10-CM and ICD-10-PCS guidelines
  - Discuss documentation requirements related to specific coding guidelines
ICD-10-CM/PCS Official Coding Guidelines

- ICD-10-CM:

- ICD-10-PCS:
ICD-10-CM Official Guidelines for Coding and Reporting

• Sections:
  – I. Conventions, General Coding Guidelines, and Chapter-Specific Guidelines
    • Applicable to all healthcare settings unless otherwise indicated
    • Conventions and instructions of the classification take precedence over guidelines
  – II. Selection of Principal Diagnosis
  – III. Reporting Additional Diagnoses
  – IV. Diagnostic Coding and Reporting Guidelines for Outpatient Services
  – Appendix I: Present on Admission Reporting Guidelines
NEC and NOS

• **NEC: Not elsewhere classifiable**
  - Represents “other specified” — when a specific code is not available for a condition, the Alphabetic Index directs the code to the “other specified” code in the Tabular List
  - Caution: Not everything is other specified

• **NOS: Not otherwise specified**
  - This is the equivalent of unspecified — when the information in the record is insufficient to assign a more specific code
Excludes

- Excludes1: means “not coded here”—the code excluded should never be used at the same time as the code above the Excludes1 note. Excludes1 is used when two conditions cannot occur together.
  - Exception: The circumstance when the two conditions are unrelated to each other. If it is not clear whether the two conditions are related, query the provider.
- Excludes2: means “not included here”—the condition excluded is not part of the condition represented by the code, but a patient may have both conditions at the same time.
Coding Clinic, Fourth Quarter 2018, page 88

Question:

- Both code D53.9, Nutritional anemia, unspecified, and code D64.9, Anemia, unspecified, are nonspecific codes. Code D53.9 has an Excludes1 note in the Tabular List for “anemia NOS (D64.9).” How should the Excludes1 notes be interpreted, and when both conditions are documented in the medical record, which condition should be coded?

Answer:

- If provider documentation indicates both nutritional anemia and anemia, assign only code D53.9, Nutritional anemia, unspecified. Code D53.9 indicates a type of anemia and code D64.9, Anemia, unspecified, does not provide any additional information about the patient. It would be contradictory to have a code for unspecified and another specified code for the same condition.
Question:
- The patient has been diagnosed with an acute myocardial infarction (AMI) and chronic total occlusion of the coronary artery. There is an Excludes1 note at code I25.82, Chronic total occlusion of coronary artery, which excludes “acute coronary occlusion with myocardial infarction (I21.-, I22.-).” However, in this case, the occlusion and myocardial infarction are in different arteries. Is it acceptable to assign a code for both the acute MI and the chronic total occlusion?

Answer:
- In this case, it is appropriate to assign a code for the acute MI along with code I25.82, Chronic total occlusion of coronary artery. Since the chronic total occlusion of the coronary artery and the acute MI occurred in different vessels, they are not related.
- The *Official Guidelines for Coding and Reporting* regarding the Excludes1 notes states, “An exception to the Excludes1 definition is the circumstance when the two conditions are unrelated to each other.”
With

• 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”).
Question:

- Since ICD-10-CM presumes a relationship between both chronic kidney disease (CKD) and hypertension as well as diabetes mellitus and CKD, what are the appropriate code assignments when the provider documents type 2 diabetes mellitus with chronic kidney disease and the patient also has a diagnosis of hypertension?
Answer:
Assign codes
- E11.22, Type 2 diabetes mellitus with diabetic chronic kidney disease,
- I12.9, Hypertensive chronic kidney disease with stage 1-4 CKD, and
- N18.9, Chronic kidney disease, unspecified.

The classification presumes a cause-and-effect relationship between both diabetes and CKD and hypertension and CKD. CKD is most likely related to both hypertension and diabetes when the patient has all three conditions. Both high blood sugar and high pressure in the blood vessels will cause the vessels to deteriorate, which can then damage the kidneys.
Question:

There remains confusion about the correct coding of diabetes “with” associated conditions, and coding professionals are seeking guidance and clarity from Coding Clinic. For example, a patient is diagnosed with type 2 diabetes and arthritis. The provider has not linked the two conditions. However, there is an index entry for “diabetes with arthropathy.” Since arthritis is a form of arthropathy, would it be appropriate to assign code E11.618, Type 2 diabetic arthropathy?

This condition can be found in the Alphabetic Index as follows:

- Diabetes, diabetic (mellitus) (sugar)
  - with
    - arthropathy NEC E11.618
Answer:

- 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.”

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.”
**Case Example: Diabetes with ...**

- **Provider documentation:**
  - Clinic visit, addressing the following issues
    - Left heel pressure ulcer, stage 1—continued healing with regular dressing changes
    - Hypertension—controlled on daily Lisinopril, continue as prescribed
    - Type 2 diabetes mellitus—A1C of 6.8 with daily insulin use, continue

- What is the correct coding of this visit?
Case Example: *Diabetes with ...*

### Potential code choices:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>L89.620</td>
<td>Pressure ulcer of left heel, unstageable</td>
</tr>
<tr>
<td>L89.621</td>
<td>Pressure ulcer of left heel, stage 1</td>
</tr>
<tr>
<td>I10</td>
<td>Essential (primary) hypertension</td>
</tr>
<tr>
<td>I15.2</td>
<td>Hypertension, secondary to endocrine disorder</td>
</tr>
<tr>
<td>I15.9</td>
<td>Secondary hypertension, unspecified</td>
</tr>
<tr>
<td>E11.59</td>
<td>Type 2 diabetes mellitus with other circulatory complications</td>
</tr>
<tr>
<td>E11.621</td>
<td>Type 2 diabetes mellitus with foot ulcer</td>
</tr>
<tr>
<td>E11.9</td>
<td>Type 2 diabetes mellitus without complications</td>
</tr>
<tr>
<td>Z79.4</td>
<td>Long term (current) use of insulin</td>
</tr>
</tbody>
</table>

**a.** E11.621, L89.621, E11.59, I10, Z79.4  
**b.** E11.621, L89.621, E11.9, I10, Z79.4  
**c.** L89.621, I10, E11.9, Z79.4  
**d.** E11.621, L89.621, E11.59, I15.2, Z79.4
Question:

• A 79-year-old male with type 2 diabetes mellitus presented due to acute cellulitis of the left lower leg. The patient was admitted and started on broad-spectrum antibiotics. When assigning the diabetes code, would it be appropriate to report the code for diabetes “with skin complication NEC?” What is the appropriate code assignment for cellulitis in a patient with type 2 diabetes?
Answer:

- In order to link the diabetes and the cellulitis, the provider would need to document cellulitis as a diabetic skin complication. When the causal relationship is unclear, query the provider regarding the linkage and whether cellulitis is a skin complication caused by the diabetes. Each case is patient specific, and the relationship between diabetes and cellulitis should be clearly documented by the provider. When the coder is unable to determine whether a condition is a diabetic complication, or the ICD-10-CM classification does not provide instruction, it is appropriate to query the physician for clarification so that the appropriate codes may be reported.

- “Diabetes with skin complication NEC,” is indexed, but “diabetes with cellulitis” is not specifically indexed. 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”. Coding professionals should not assume a causal relationship when the diabetic complication is “NEC.” The ICD-10-CM classification presumes a cause and effect relationship with certain specific conditions when the Alphabetic Index links the conditions by the terms “with”, “due to” or “associated with”.

Code Assignment and Clinical Criteria

• The assignment of a diagnosis code is based on the provider’s diagnostic statement that the condition exists. The provider’s statement that the patient has a particular condition is sufficient. Code assignment is not based on clinical criteria used by the provider to establish the diagnosis.
Documentation by Clinicians

- Documentation by clinicians other than the patient’s provider: **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 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 ...
- The associated diagnosis (overweight, obesity, acute stroke or pressure ulcer) must be documented by the patient’s provider.
- Conflicting documentation? Query!
Question:

- If the provider documents obesity or morbid obesity in the history and physical and/or discharge summary only, without any additional documentation to support the clinical significance of this condition, can it be coded? There is no other documentation to support clinical significance for this condition such as evaluation, treatment, increased monitoring, or increased nursing care, etc.

Answer:

- Obesity and morbid obesity are always clinically significant and reportable when documented by the provider. In addition, if documented, the body mass index (BMI) code may be coded in addition to the obesity or morbid obesity code.

**Monitor denials surrounding morbid obesity secondary diagnosis codes.**
Additional Coding Clinic Guidance

- Fourth Quarter 2016, pages 147–149
- *It is appropriate for facilities to ensure that documentation is complete, accurate, and appropriately reflects the patient’s clinical conditions.*
- ... *Clinical validation is a separate function from the coding process and clinical skill.*
- *Clinical validation is an additional process that may be performed along with DRG validation.*
- *Clinical validation is beyond the scope of DRG (coding) validation, and the skills of a certified coder.*
Hypertension With Heart Disease

- Hypertension with heart conditions classified to I50.- or I51.4–I51.7, I51.89, I51.9, are assigned to a code from category I11, Hypertensive heart disease. Use additional code(s) from category I50, Heart failure, to identify the type(s) of heart failure.
- The same heart conditions (I50.- or I51.4–I51.7, I51.89, I51.9) with hypertension are **coded separately** if the provider has documented they are unrelated to the hypertension. Sequence according to the circumstances of the admission/encounter.
Hypertensive Chronic Kidney Disease

• Assign codes from category I12, Hypertensive chronic kidney disease, when both hypertension and a condition classifiable to category N18, Chronic kidney disease (CKD), are present

• CKD should not be coded as hypertensive if the provider indicates the CKD is not related to the hypertension
Hypertensive Heart and Chronic Kidney Disease

• Assign codes from combination category I13, Hypertensive heart and chronic kidney disease, when there is hypertension with both heart and kidney involvement
• If heart failure is present, assign an additional code from category I50 to identify the type of heart failure
• The appropriate code from category N18, Chronic kidney disease, should be used as a secondary code with a code from I13 to identify the stage of chronic kidney disease
• Category I13—combination codes that include hypertension, heart disease, and chronic kidney disease
Acute Myocardial Infarction (AMI)

- Subsequent acute myocardial infarction
  - If a subsequent myocardial infarction of one type occurs within 4 weeks of a myocardial infarction of a different type, assign the appropriate codes from category I21 to identify each type. Do not assign a code from I22. Codes from category I22 should only be assigned if both the initial and subsequent myocardial infarctions are type 1 or unspecified.
  - Documentation of type/site of myocardial infarction.
ICD-10-PCS Official Guidelines for Coding and Reporting
ICD-10-PCS – A11

• Many of the terms used to construct PCS codes are defined within the system. It is the coder’s responsibility to determine what the documentation in the medical record equates to in the PCS definitions.

• The physician is not expected to use the terms used in PCS code descriptions, nor is the coder required to query the physician when the correlation between the documentation and the defined PCS terms is clear.

• *Example:* When the physician documents “partial resection,” the coder can independently correlate “partial resection” to the root operation Excision without querying the physician for clarification.
ICD-10-PCS – B3.1a

- In order to determine the appropriate root operation, the full definition of the root operation as contained in the PCS Tables must be applied

- **Resection: Cutting out or off, without replacement, all of a body part**
Changing advice from *Coding Clinic*

**Question:** ... Admitted for prophylactic left mastectomy and bilateral deep inferior epigastric artery perforator (DIEP) flap reconstruction. ... Should the harvesting of the DIEP flap be coded separately? Additionally, in ICD-10-PCS is a mastectomy with breast replacement/reconstruction analogous to joint replacement surgery, in which the resection of the joint is not coded separately?
• **Answer:** No, the harvesting of the DIEP flap is not coded separately as this information would not add value to the coded data. ... Use root operation “Replacement” ...

• Mastectomy with breast replacement/reconstruction and joint replacement surgery are conceptually very different. In joint replacement, the objective is to restore function by replacing the joint. For a mastectomy with reconstruction, it is important to identify that the primary objective of the surgery is to remove cancerous or potentially cancerous breast tissue, and that the reconstruction is an additional objective.

• **Assign root operations:** Replacement, Resection, and Removal.
ICD-10-PCS: Multiple Procedures

During the same operative episode, multiple procedures are coded if:

a) The same root operation is performed on different body parts as defined by distinct values of the body part character.

b) The same root operation is repeated in multiple body parts, and those body parts are separate and distinct body parts classified to a single ICD-10-PCS body part value.

c) Multiple root operations with distinct objectives are performed on the same body part.

d) The intended root operation is attempted using one approach but is converted to a different approach.
Transfer Procedures Using Multiple Tissue Layers

- B3.17: The root operation Transfer contains qualifiers that can be used to specify when a transfer flap is composed of more than one tissue layer, such as a musculocutaneous flap.
- For procedures involving transfer of multiple tissue layers including skin, subcutaneous tissue, fascia, or muscle, the procedure is coded to the body part value that describes the deepest tissue layer in the flap.
- The qualifier can be used to describe the other tissue layer(s) in the transfer flap.
ICD-10-PCS Guideline B6 Device

• Wording changes for FY 2019
  – In limited root operations, the classification provides the qualifier values Temporary and Intraoperative, for specific procedures involving clinically significant devices, where the purpose of the device is to be utilized for a brief duration during the procedure or current inpatient stay. **If a device that is intended to remain after the procedure is completed requires removal before the end of the operative episode in which it was inserted (for example, the device size is inadequate or a complication occurs), both the insertion and removal of the device should be coded.**
Question:
• A patient underwent coronary artery bypass grafting to four vessels including internal mammary to the left anterior descending (LAD), a reverse saphenous vein graft placed to the obtuse marginal (OM), the posterolateral branch (PLB) and the posterior descending (PDA) arteries. An endarterectomy was performed to a segment of the PDA prior to performing the distal anastomosis. Is it appropriate to assign a separate code for the endarterectomy or is it inherent to the CABG surgery?

Answer:
• Assign a code for the bypass procedure only. When the endarterectomy is done to prepare the artery for the bypass surgery the endarterectomy would not be coded separately. The endarterectomy is only reported when there is a separate and distinct procedural objective.
Thank you. Questions?

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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.