Coding Clinic Update

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Presenter

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  – Internal medicine – the University of Tennessee
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Learning Objectives

• At the completion of this educational activity, the learner will be able to:
  
  – Explain the structure of ICD-10-CM/PCS coding conventions, guidelines, and official advice essential to understanding Coding Clinic advice
  
  – Outline the history, authority, and utility of the 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 engages Coding Clinic to help us solve challenges with ICD-10
Foundations

*Coding Clinic for ICD-10-CM/PCS*
The AHA Central Office
Origins and Goals

• Created through a written Memorandum of Understanding between the American Hospital Association (AHA) and the National Center for Health Statistics (NCHS) in 1963 to:
  – Serve as the U.S. clearinghouse for issues related to the use of ICD-9-CM and ICD-10
  – Work with NCHS, the Centers for Medicare & Medicaid Services (CMS), and AHIMA (American Health Information Management Association)—known as the Cooperating Parties—to maintain the integrity of the classification system
  – Recommend revisions and modifications to the current and future revisions of the ICD
  – Develop educational material and programs on ICD-9-CM and ICD-10

• Whereas the ICD-9-CM or ICD-10-CM/PCS transaction sets (supplemented by the Guidelines) are the Constitution, Coding Clinic serves as the Supreme Court in interpreting ICD-9-CM or ICD-10-CM/PCS and their guidelines. Its advice is official.
The AHA Central Office Staff

Nelly Leon-Chisen, RHIA
- Director, Coding and Classification & Executive Editor for *AHA Coding Clinic for ICD-10-CM/PCS* and *AHA Coding Clinic for HCPCS*

- Senior coding consultants
  - Gretchen Young-Charles, RHIA
  - Anita Rapier, RHIT, CCS
  - Benjamin D. Oden, RHIT, CCS, CCS-P
  - Denene M. Harper, RHIA

- Coding consultants
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- Project coordinator
  - Karen Ayala, RHIT
The AHA Central Office
Editorial Advisory Board (EAB)

• The EAB for *Coding Clinic for ICD-10-CM/PCS* was developed to ensure that the needs of users of these classification systems are addressed
  – Assists hospitals/networks in collecting and reporting standardized quality data by:
    • Advocating to ensure data used by integrated information systems and federal programs is based upon clearly defined and uniform standards
    • Serving as the authoritative source of coding/classification information
  • Meets quarterly for 2–3 days (or as needed) to address issues brought to them by Central Office staff
    – Reactive to Central Office issues, not proactive
    – Meetings are NOT open to the public
    – EAB members are sworn to secrecy on their deliberations
The AHA Central Office
EAB Membership – Voluntary

• Cooperating Parties
  – Donna Pickett, RHIA – CDC (responsible for diagnoses)
  – Mady Hue, RHIA – CMS (responsible for procedures)
  – Nelly Leon-Chisen – AHA - Editor of Coding Clinic
  – Sue Bowman, RHIA – AHIMA

• Donna Ganzer – Chairman
  – Retired AHA executive

• Coders from the provider community, such as
  – Vanderbilt University, Sutter Health, Opelousas General Hospital

• Providers (practicing MDs) representing
  – American Medical Association
  – American College of Physicians
  – American College of Surgeons
  – American Academy of Pediatrics
  – Veterans Administration Health Care System

• Invited guests or Cooperating Party employees/contractors (not credited)
  – 3M Health Information Systems (ICD-10-PCS)
  – CMS Medical Directors

Consultants are prohibited from membership, even if nominated
The AHA Central Office
Coding Clinic for ICD-10-CM/PCS

Published *Coding Clinic for ICD-9-CM* (quarterly) from 1983 to 2014; for ICD-10-CM/PCS 2012-now

- Deemed by the Cooperating Parties as the official publication for ICD-10 coding guidelines and advice
  - Most advice published in *Coding Clinic* has been vetted by their Editorial Advisory Board
  - No advice can be published unless unanimously agreed upon by the four Cooperating Parties

- **Coding Clinic (CC), 1st Quarter 2007, p. 19**
  The guidelines and directives in the ICD-9-CM manual take precedence over advice published in *Coding Clinic*

- **Coding Clinic (CC), 1st Quarter 2011, p. 19**
  Changes in the ICD-9-CM classification supersede previously published *Coding Clinic* advice
Obtaining **Coding Clinic Advice**

**Subscribing**

- **Subscriptions available:**
  - Paper
  - Electronic
  - On many encoders (e.g., 3M, TruCode, Optum, Nuance)

**AHA Coding Clinic® for ICD-10-CM**
A quarterly publication of the Central Office on ICD-9-CM

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Foundations
Coding 101
Diagnoses

ICD-10-CM Hierarchy

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 or influence sequencing

4. Advice from the Coding Clinic for ICD-10-CM/PCS
   - May add or subtract codes or influence sequencing
   - Occasionally can overrule the Index, Table, and Guidelines

5. Court opinions or other payer-specific regulations
How to Look Up a Diagnosis Code

Chronic Kidney Disease

Essential to use both the Index (first) and then the Table when looking up a code!
Exception to the Rule

Patient presents with ascites due to cirrhosis due to Hepatitis C

K71.51 Toxic liver disease with chronic active hepatitis with ascites

Assign codes
- B18.2, Chronic viral hepatitis C,
- K74.60, Unspecified cirrhosis of liver, and
- R18.8, Other ascites, to capture these conditions.

_Coding Clinic_, 1st Quarter, 2018, pages 4-5
Exception to the Rule

• Although the Index entries for these conditions may be confusing, a basic rule of coding is that further research/review may be required, if the code indexed does not identify the condition correctly.

• While the ascites is due to the cirrhosis, and the cirrhosis is due to the chronic viral hepatitis C (HCV), ascites is not always present with these conditions, so it is appropriate to convey the full clinical picture and assign an additional code for the ascites.
  – Essence of what’s integral and what’s not w/symptom codes

*Coding Clinic*, 1st Quarter, 2018, pages 4-5
Diagnoses

ICD-10-CM Official Guidelines

ICD-10-CM Official Guidelines for Coding and Reporting
FY 2018
(October 1, 2017 - September 30, 2018)

Narrative changes appear in bold text
Items underlined have been moved within the guidelines since the FY 2017 version
Italics are used to indicate revisions to heading changes

The Centers for Medicare and Medicaid Services (CMS) and the National Center for Health Statistics (NCHS), two departments within the U.S. Federal Government’s Department of Health and Human Services (DHHS) provide the following guidelines for coding and reporting using the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM). These guidelines should be used as a companion document to the official version of the ICD-10-CM as published on the NCHS website. The ICD-10-CM is a morbidity classification published by the United States for classifying diagnoses and reason for visits in all health care settings. The ICD-10-CM is based on the ICD-10, the statistical classification of disease published by the World Health Organization (WHO).

• An essential reference that must be read over and over and over again. Available for free at:
• http://www.tinyurl.com/2018ICD10CMguidelines
Excludes1 Note

• Excludes1 A type 1 Excludes note is a pure excludes note. It means “NOT CODED HERE!”
  – An Excludes1 note indicates that the code excluded should never be used at the same time as the code above the Excludes1 note. **An Excludes1 is used when two conditions cannot occur together, such as a congenital form versus an acquired form of the same condition.**

• An exception to the Excludes1 definition is the circumstance when the two conditions are unrelated to each other. **If it is not clear whether the two conditions involving an Excludes1 note are related or not, query the provider.**
  – For example, code F45.8, Other somatoform disorders, has an Excludes1 note for "sleep related teeth grinding (G47.63)," because "teeth grinding" is an inclusion term under F45.8. Only one of these two codes should be assigned for teeth grinding. However psychogenic dysmenorrhea is also an inclusion term under F45.8, and a patient could have both this condition and sleep related teeth grinding. In this case, the two conditions are clearly unrelated to each other, and so it would be appropriate to report F45.8 and G47.63 together.
2018 ICD-10-CM Official Guidelines
The Word “With” or “In”

• “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, 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”).
Sepsis “With” Organ Dysfunction

Index and Table say that sepsis and organ dysfunction are automatically linked

The Guidelines state: An acute organ dysfunction must be associated with the sepsis in order to assign the severe sepsis code. If the documentation is not clear as to whether an acute organ dysfunction is related to the sepsis or another medical condition, query the provider.
Procedures
ICD-10-PCS Hierarchy

1. ICD-10-PCS Index
   - The purpose of the alphabetic index is to locate the appropriate table that contains all information necessary to construct a procedure code. The PCS Tables should always be consulted to find the most appropriate valid code.

2. ICD-10-PCS Table
   - It is not required to consult the index first before proceeding to the tables to complete the code. A valid code may be chosen directly from the tables.

3. ICD-10-PCS Official Guidelines for Coding and Reporting
   - May add or subtract codes or influence sequencing

4. Advice from the *Coding Clinic for ICD-10-CM/PCS*
   - May add or subtract codes or influence sequencing
   - Sometimes can overrule the Index, Table, and Guidelines

5. Court opinions or other payer-specific regulations
Objectives and Mechanics of Procedure
ICD-10-PCS Guidelines

Occlusion vs. Restriction for vessel embolization procedures
B3.12
• If the objective of an embolization procedure is to completely close a vessel, the root operation Occlusion is coded.
• If the objective of an embolization procedure is to narrow the lumen of a vessel, the root operation Restriction is coded.

Examples:
• Tumor embolization is coded to the root operation Occlusion, because the objective of the procedure is to cut off the blood supply to the vessel.
• Embolization of a cerebral aneurysm is coded to the root operation Restriction, because the objective of the procedure is not to close off the vessel entirely, but to narrow the lumen of the vessel at the site of the aneurysm where it is abnormally wide.
Tubal “Ligation”

• While the objective of the procedure is to occlude the lumen of the Fallopian tube, there are different techniques, such as the following root operations:
  – Excision
  – Destruction
  – Occlusion (using clips)

• Sometimes, a query is needed to determine both the objective of a procedure and the mechanics of how it was done

_Coding Clinic, 1st Quarter, 2018_
Coding Rules
CDI Lessons

- Learn how to use the Index, Table, Guidelines, and Coding Clinic advice
  - Great bridge builders between CDI teams and coders
- Coding Clinic is available to all invested in documentation integrity
  - Must be advocated in light of the patient’s clinical indicators, the provider’s documentation, and official coding rules
COPD and Asthma
COPD – Asthma Overlap Syndrome

http://goldcopd.org/asthma-copd-asthma-copd-overlap-syndrome/

Permission given to reproduce this graphic.
Key Clinical Indicators

• Approximately 20% of patients with COPD have asthma as an overlap
  – Onset after age 40, but may have had symptoms in childhood
• COPD symptoms
  – Airflow limitations not fully reversible between exacerbations
  – Hyperinflation on CXR
• Asthma symptoms
  – Usually childhood symptoms, MD-diagnosed asthma, history of allergies or noxious exposures
  – Significant improvement with treatment
  – Eosinophils in sputum

Gibson PG, McDonald VM. Asthma–COPD overlap 2015: now we are six. Thorax 2015;70:683-691.
Paraphrased question – If someone has COPD and asthma together, should only the COPD code be assigned?

Paraphrased answer – If no asthma specificity is documented, then only code the COPD code. If a specified form of asthma is documented, then code the specified form of asthma. Options include:

- Mild intermittent
- Mild persistent
- Moderate persistent
- Severe persistent
J44 – Code Also Note for Asthma

J44 Other chronic obstructive pulmonary disease

Includes: asthma with chronic obstructive pulmonary disease
chronic asthmatic (obstructive) bronchitis
chronic bronchitis with airways obstruction
chronic bronchitis with emphysema
chronic emphysematous bronchitis
chronic obstructive asthma
chronic obstructive bronchitis
chronic obstructive tracheobronchitis

Code also type of asthma, if applicable (J45.-)

The key phrase is “type of asthma”
Unspecified asthma is not a “type of asthma”
Exacerbated Asthma with COPD

• *Coding Clinic*, 1st Quarter, 2017 Page: 26
  – Exacerbation of COPD does not necessarily mean that any coexisting asthma is also exacerbated
    • Requires documentation that both are exacerbated at the same time.

• *Coding Clinic*, 4th Quarter, 2017, pp. 96-97
  – While exacerbated asthma is not a “type” of asthma, it does add additional information about the type of asthma.
    • As such, if exacerbated asthma coexists with COPD, it may be coded without the specified type
### DRG Impact

<table>
<thead>
<tr>
<th>Exacerbated COPD Asthma</th>
<th>MS-DRG 192 COPD w/o CC/MCC 0.7265</th>
<th>APR DRG 140 COPD SOI 1 (0.493) ROM 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exacerbated COPD A specified type of asthma (e.g. mild intermittent)</td>
<td>MS-DRG 192 COPD w/o CC/MCC 0.7265</td>
<td>APR DRG 140 COPD SOI 1 (0.493) ROM 1</td>
</tr>
<tr>
<td>Exacerbated COPD (PDx) Exacerbated Asthma</td>
<td>MS-DRG 191 COPD w/CC 0.9176</td>
<td>APR DRG 140 COPD SOI 2 (0.6227) ROM 1</td>
</tr>
<tr>
<td>Exacerbated COPD (PDx) Exacerbated specific type of asthma</td>
<td>MS-DRG 191 COPD w/CC 0.9176</td>
<td>APR DRG 140 COPD SOI 2 (0.6227) ROM 1</td>
</tr>
<tr>
<td>Exacerbated Asthma (PDx) Exacerbated COPD</td>
<td>MS-DRG 202 Asthma w/CC/MCC 0.9260</td>
<td>APR DRG 141 Asthma SOI 2 (0.5467) ROM 1</td>
</tr>
</tbody>
</table>
Exacerbation of COPD in the Setting of Emphysema

Disease
- pulmonary -see also Disease, lung
- - artery I28.9
- chronic obstructive J44.9
- - with
- - - acute bronchitis J44.0
- - - exacerbation (acute) J44.1
- - - lower respiratory infection (acute) J44.0
- - decompensated J44.1
- - - with
- - - exacerbation (acute) J44.1

Emphysema (atrophic) (bullous) (chronic) (interlobular) (lung) (obstructive) (pulmonary) (senile) (vesicular) J43.9
- - centrilobular J43.2
- - panacinar J43.1
- - panlobular J43.1
- - specified NEC J43.8
- unilateral J43.0

Note there is no code for “decompensated emphysema”

COPD is APR-DRG SOI of 2
COPD is MS-DRG CC only if decompensated

Not a CC in MS-DRGs
SOI of 2 in APR-DRGs
Can Emphysema and COPD Be Coded Together?

- The term, “COPD”, is an overarching term that encompasses
  - Small airway disease
  - Lung destruction
- Emphysema refers only to the pathology that occurs with COPD. Others may be present, such as
  - Bronchiectasis
  - Pulmonary fibrosis
  - Others
J44 Other chronic obstructive pulmonary disease

Includes: asthma with chronic obstructive pulmonary disease
chronic asthmatic (obstructive) bronchitis
chronic bronchitis with airways obstruction
chronic bronchitis with emphysema
chronic emphysematous bronchitis
chronic obstructive asthma
chronic obstructive bronchitis
chronic obstructive tracheobronchitis

Code also type of asthma, if applicable (J45.-)

Use additional code to identify:
   exposure to environmental tobacco smoke (Z77.22)
   history of tobacco dependence (Z87.891)
   occupational exposure to environmental tobacco smoke (Z57.31)
   tobacco dependence (F17.-)
   tobacco use (Z72.0)

Excludes1: bronchiectasis (J47.-)
   chronic bronchitis NOS (J42)
   chronic simple and mucopurulent bronchitis (J41.-)
   chronic tracheitis (J42)
   chronic tracheobronchitis (J42)
   emphysema without chronic bronchitis (J43.-)

EXCLUDES1 NOTE: NOT CODED HERE!
ICD-10-CM’s Approach

J43 Emphysema

Use additional code to identify:
- exposure to environmental tobacco smoke (Z77.22)
- history of tobacco dependence (Z87.891)
- occupational exposure to environmental tobacco smoke (Z57.31)
- tobacco dependence (F17-)
- tobacco use (Z72.0)

Excludes1: compensatory emphysema (J98.3)
- emphysema due to inhalation of chemicals, gases, fumes or vapors (J68.4)
  - emphysema with chronic (obstructive) bronchitis (J44-)
  - emphysematous (obstructive) bronchitis (J44-)
- interstitial emphysema (J98.2)
- mediastinal emphysema (J98.2)
- neonatal interstitial emphysema (P25.0)
- surgical (subcutaneous) emphysema (T81.82)
- traumatic subcutaneous emphysema (T79.7)

EXCLUDES1 NOTE: NOT CODED HERE!
Coding Clinic, 4th Quarter, 2017, page 98

• With the documentation of emphysema and decompensated COPD, only code the emphysema code, NOT the decompensated COPD code
  – Coding Clinic (in my opinion, erroneously) opined that emphysema is a subset of COPD
  – Consequently, J44.1 cannot be coded, losing a MS-DRG CC

• Suggestions:
  – Read the Global Initiative for Chronic Obstructive Lung Disease (GOLD) Global Strategy for the Diagnosis, Management and Prevention of COPD, available at: https://tinyurl.com/2017GOLDemphysema
  – Encourage physicians not to use the word “emphysema” unless they are absolutely sure that the patient does not have some form of obstructive bronchiolitis.
  – Write Coding Clinic to tell them what you think of this advice.
Encephalopathy
MDC 1 – Encephalopathy
Global Disease or Dysfunction

• Adams and Victor Neurology, 10e - Global disturbance of cerebral function
• NIH – any diffuse disease of the brain that alters brain function or structure.
  – May be caused by infectious agent (bacteria, virus, or prion), metabolic or mitochondrial dysfunction, brain tumor or increased pressure in the skull, prolonged exposure to toxic elements (including solvents, drugs, radiation, paints, industrial chemicals, and certain metals), chronic progressive trauma, poor nutrition, or lack of oxygen or blood flow to the brain.
  – The hallmark of encephalopathy is an altered mental state.

www.ninds.nih.gov/disorders/encephalopathy/encephalopathy.htm
MDC 1 – Encephalopathy
Multiple Options in ICD-10-CM

Encephalopathy (acute) G93.40
- acute necrotizing hemorrhagic G04.30
  - postimmunization G04.32
  - postinfectious G04.31
  - specified NEC G04.39
  - alcoholic G31.2
  - anoxic —see Damage, brain, anoxic
  - arteriosclerotic I67.2
  - centrolobar progressive (Schilder) G37.0
  - congenital Q07.9
  - degenerative, in specified disease NEC G32.89
  - demyelinating callosal G37.1
  - due to
    - drugs (see also Table of Drugs and Chemicals) G92
      - hepatic —see Failure, hepatic
      - hyperbilirubinemic, newborn P57.9
      - due to isoimmunization (conditions in P55) P57.0
      - hypertensive I67.4
      - hypoglycemic E16.2
      - hypoxic —see Damage, brain, anoxic
      - hypoxic ischemic P91.60
      - mild P91.61
      - moderate P91.62
      - severe P91.63
    - in (due to) (with)
      - birth injury P11.1
      - hyperinsulinism E16.1 [G94]
      - influenza —see Influenza, with, encephalopathy
      - lack of vitamin (see also Deficiency, vitamin) E56.9 [G32.89]
      - neoplastic disease (see also Neoplasm) D49.9 [G13.1]
      - serum (see also Reaction, serum) T80.69
      - syphilis A52.17
      - trauma (postconcussional) F07.81
      - current injury —see Injury, intracranial
      - vaccination G04.02
      - lead —see Poisoning, lead
    - metabolic G93.41
      - drug induced G92
      - toxic G92
        - myoclonic, early, symptomatic —see Epilepsy, generalized, specified NEC
    - necrotizing, subacute (Leigh) G31.82
    - pellagrous E52 [G32.89]
    - portosystemic —see Failure, hepatic
    - postcontusional F07.81
    - current injury —see Injury, intracranial, diffuse
    - posthypoglycemic (coma) E16.1 [G94]
    - postradiation G93.89
    - saturnine —see Poisoning, lead
    - septic G93.41
    - specified NEC G93.49
    - spongioform, subacute (viral) A81.09
    - toxic G92
      - traumatic (postconcussional) F07.81
      - current injury —see Injury, intracranial
      - vitamin B deficiency NEC E53.9 [G32.89]
      - vitamin B1 E51.2
      - Wernicke's E51.2

(Acute) Encephalopathy is unspecified – warrants query
Red = MCC  Green = Special Emphasis – G94 code
(Acute) Encephalopathy “in” a Disease (e.g. UTI) Not Classified In the Index

G93.4 Other and unspecified encephalopathy
   Excludes1: alcoholic encephalopathy (G31.2)
   encephalopathy in diseases classified elsewhere (G94)
   hypertensive encephalopathy (I67.4)
   toxic (metabolic) encephalopathy (G92)

G93.40 Encephalopathy, unspecified

G93.41 Metabolic encephalopathy
   Septic encephalopathy

G93.49 Other encephalopathy
   Encephalopathy NEC

G94 Other disorders of brain in diseases classified elsewhere
   Code first underlying disease
   Excludes1: encephalopathy in congenital syphilis (A50.49)
   encephalopathy in influenza (J09.X9, J10.81, J11.81)
   encephalopathy in syphilis (A52.19)
   hydrocephalus in diseases classified elsewhere (G91.4)

} A MCC

NOT A MCC
Encephalopathy (w/ & w/o Adjective) Due to UTI

**Medicare DRG and MDC Information**

092

**OTHER DISORDERS OF NERVOUS SYSTEM W CC**

CMS wt 0.9075 ALOS 3.8 GLOS 3.1

Length of stay, discharge to a post-acute care provider, and home health service condition codes can significantly impact reimbursement for this DRG.

001

**DISEASES & DISORDERS OF THE NERVOUS SYSTEM**

Estimated Reimbursement -- Medicare Inpatient

Total: $5615.53

Status: Inlier

APR (all versions) DRG and MDC Information

052

**NONTRAUMA STUPOR & COMA**

APR wt 0.8924 Low Trim 1 High Trim 18 ALOS 4.67 GLOS 3.72

Status: LOS Inlier

001

**NERVOUS SYSTEM**

3 Major Severity of Illness

1 Minor Risk of Mortality

Admit Diagnosis

G92 Toxic encephalopathy

Principal Diagnosis

*G92 Toxic encephalopathy

Affects secondary DRG

*SOL=P Principal diagnosis used for SOI calculation

*ROM=P Principal diagnosis used for ROM calculation

Secondary Diagnoses

*N390 Urinary tract infection, site not specified

*SOI=2 Moderate

*ROM=1 Minor

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**Medicare DRG and MDC Information**

690

**KIDNEY & URINARY TRACT INFECTIONS WO MCC**

CMS wt 0.7928 ALOS 3.7 GLOS 3.1

Length of stay, discharge to a post-acute care provider, and home health service condition codes can significantly impact reimbursement for this DRG.

011

**DISEASES & DISORDERS OF THE KIDNEY & URINARY TRACT**

Estimated Reimbursement -- Medicare Inpatient

Total: $4974.83

Status: Inlier

APR (all versions) DRG and MDC Information

463

**KIDNEY/URINARY TRACT INFECTION**

APR wt 0.5233 Low Trim 1 High Trim 10 ALOS 3.33 GLOS 2.87

Status: LOS Inlier

011

**KIDNEY & URINARY TRACT**

2 Moderate Severity of Illness

1 Minor Risk of Mortality

Admit Diagnosis

G92 Toxic encephalopathy

Principal Diagnosis

*N390 Urinary tract infection, site not specified

*SOI=2 Moderate

*ROM=1 Minor

Secondary Diagnoses

G94 Other disorders of brain in diseases classified elsewhere (manifestation)

*SOI=2 Moderate

*ROM=2 Moderate

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**Toxic Metabolic Encephalopathy 2° UTI**

G92 – Toxic Encephalopathy As PDx

(Acute) Encephalopathy due to UTI N390 – UTI as PDx
**Coding Clinic, 2nd Quarter, 2017, pp 8-9**

**Appropriate Use of G94**

- **Question:** Patient admitted with septic-associated encephalopathy. Which code do I use, G93.41, Metabolic encephalopathy, or G94 for Encephalopathy in Diseases Classified Elsewhere (per the Excludes1 note)

- **Answer:**
  1. First use the Index to Diseases – Septic encephalopathy goes to G93.41.
  2. Second, while there is an Excludes1 note for G93.4x, G94 should only be used if it is referenced in the Index. If no specified type of encephalopathy is documented, use G93.40

**NOTE:** In a personal communication, the Central Office stated that encephalopathy due to UTI uses G93.40, not G94
Where Does the Index Use G94?

- Cyst (colloid) (mucous) (simple) (retention)
  - brain (acquired) G93.0
    - hydatid B67.99 [G94]
  - hydatid -see also Echinococcus B67.90
    - brain B67.99 [G94]

- Disease, diseased -see also Syndrome
  - brain G93.9
    - parasitic NEC B71.9 [G94]
  - parasitic B89
    - cerebral NEC B71.9 [G94]

- Encephalopathy (acute) G93.40
  - in (due to) (with)
    - hyperinsulinism E16.1 [G94]
  - posthypoglycemic (coma) E16.1 [G94]

- Epilepsy
  - parasitic NOS B71.9 [G94]

- Hyperinsulinism
  - with
    - encephalopathy E16.1 [G94]

- Malaria
  - cerebral B50.0 [G94]
  - falciparum B50.9
    - with complications NEC B50.8
      - cerebral B50.0 [G94]

- Typhus (fever) A75.9
  - brain A75.9 [G94]
  - cerebral A75.9 [G94]

One has to pay special attention to the encephalopathy in hyperinsulinism and posthypoglycemic encephalopathy.
Acute Metabolic Encephalopathy due to Hypoglycemia

- Question: Acute metabolic encephalopathy due to hypoglycemia in a patient with diabetes
- Answer:
  - PDx: E11.649, Type 2 diabetes mellitus with hypoglycemia without coma
  - SDx: G93.41, Metabolic encephalopathy (Not G94)

NOTE: I16.1 or I16.2 is for hypoglycemia not related to diabetes

**Diabetes, diabetic (mellitus) (sugar) E11.9**
- with
  - - hypoglycemia E11.649
  - - - with coma E11.641

*Coding Clinic, 3rd Quarter, 2015, page 21*
*Coding Clinic, 3rd Quarter, 2016, page 42*
Delirium Versus Encephalopathy

- **Delirium – Manifestation**
  - Acute change or fluctuation in mental status and inattention, accompanied by either disorganized thinking or an altered level of consciousness

- **Encephalopathy – Underlying Cause**
  - Global brain dysfunction

- **Dr. Kennedy’s opinion**
  - If the global brain dysfunction can be explained by a named brain disease or its exacerbation, then the term “encephalopathy” is integral
  - As such, the term “encephalopathy” is integral to defined neurodegenerative illnesses that tend to wax and wane.
Toxic Encephalopathy
Clinical Versus Coding Definitions

Clinical Definition
• Brain dysfunction caused by toxic exposure

Coding – ICD-10-CM Index to Diseases
Encephalopathy (acute) G93.40
- due to
- - drugs - -see also Table of Drugs and Chemicals G92
- - drug induced G92
- - toxic G92
- toxic G92
- - metabolite G92
Jamaican
- neuropathy G92
Leukoencephalopathy -see also
Encephalopathy G93.49
- Binswanger's I67.3
- heroin vapor G92

Note: The review cited below focuses on the most significant occupational causes of toxic encephalopathy, but does not address iatrogenic (pharmaceutical) causes or the neurotoxic effects of illicit recreational drugs or alcohol.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3521923/
Toxic Encephalopathy Code

G92 Toxic encephalopathy
  Toxic encephalitis
  Toxic metabolic encephalopathy

**Code first**, if applicable, drug induced (T36-T50) (T51-T65) to identify toxic agent

T51 Toxic effect of alcohol

The appropriate 7th character is to be added to each code from category T51
  A - initial encounter
  D - subsequent encounter
  S - sequela

T51.0 Toxic effect of ethanol
  Toxic effect of ethyl alcohol

**Excludes2:** acute alcohol intoxication or 'hangover' effects (F10.129, F10.229, F10.929)
  drunkenness (F10.129, F10.229, F10.929)
  pathological alcohol intoxication (F10.129, F10.229, F10.929)
**Coding Clinic Advice**

**Toxic Encephalopathy 2º Cipro**

- **Question:** Final diagnostic statement listed, "Toxic encephalopathy due to ciprofloxacin" with the antibiotic properly administered.

- **Answer:**
  - G92, Toxic encephalopathy, as the principal diagnosis.
  - T36.8X5A, Adverse effect of other systemic antibiotics, initial encounter, as an additional diagnosis.

*Coding Clinic, 1st Quarter, 2017, page 39*
Coding Clinic Advice
Toxic Encephalopathy 2º Lithium OD

Assign

• Code T43.592A, Poisoning by other antipsychotics and neuroleptics, intentional self harm, initial encounter, as the principal diagnosis.
• Code G92, Toxic encephalopathy, should be assigned as an additional diagnosis.

The code first note is intended to provide sequencing guidance when coding toxic effects, and does not preclude assigning code G92 along with poisoning codes.
Tips on Toxic Encephalopathy

- There must be an altered mental status of some sort
- Both the altered mental status and the underlying brain disease must be discussed
  - Delirium is the manifestation
  - Toxic encephalopathy due to drug is the underlying cause
- There must be some sense that the altered mental status is an adverse effect or that the patient has been overdosed, especially with legal mood-altering chemicals.

Coding – ICD-10-CM
Index to Diseases

Encephalopathy (acute) G93.40
- due to
  - drugs - see also
    Table of Drugs and Chemicals G92
  - metabolic G93.41
  - drug induced G92
  - toxic G92
Clinical Validity
Indications for CDI

• Address ICD-10-CM-pertinent documentation errors of omission and commission
  – Illegible – Includes meaningless copy and past
  – Inconsistent
  – Incomplete
  – Imprecise
  – Conflicting
  – Clinically invalid

• Physician documents hypernatremia; however the serum sodium is 124 meq/L
CMS Recovery Audit Contractor (RAC)
Scope of Work (SOW) – 2013:

• Clinical validation is an additional process that may be performed along with DRG validation.
  – Clinical validation involves a clinical review of the case to see whether or not the patient truly possesses the conditions that were documented in the medical record.
  – Recovery Auditor clinicians shall review any information necessary to make a prepayment or post-payment claim determination.
  – Clinical validation is performed by a clinician (RN, CMD or therapist).
  – Clinical validation is beyond the scope of DRG (coding) validation, and the skills of a certified coder.

• This type of review can only be performed by a clinician or may be performed by a clinician with approved coding credentials.
Coding is Based On What Is Documented

*Coding Clinic, 4th Quarter, 2016, pp 147-149*

• If a physician documents sepsis, code sepsis
  - In other words, regardless of whether a physician uses the new clinical criteria for sepsis, the old criteria, his personal clinical judgment, or something else to decide a patient has sepsis (and document it as such), the code for sepsis is the same—as long as sepsis is documented, regardless of how the diagnosis was arrived at, the code for sepsis can be assigned.
  - Coders should not be disregarding physician documentation and deciding on their own, based on clinical criteria, abnormal test results, etc., whether or not a condition should be coded.
Clinical Validation Workflow

*Coding Clinic, 4th Quarter, 2016, pp 147-149*

- A facility or a payer may require that a physician use a particular clinical definition or set of criteria when establishing a diagnosis, but that is a clinical issue outside the coding system.
  - Essential to standardizing everyone’s approach to CDI issues
  - Can even be written into payer contracts
Clinical Validation Workflow

Coding Clinic, 4th Quarter, 2016, pp 147-149

- **Question:** 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?

- **Answer:** 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.

  - 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.
Thank you. Questions?

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