Coding Clinic Update

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Additional slides added July 31, 2018

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Credentials:

- Internal medicine – the University of Tennessee
- AHIMA CCS – 2001
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Learning Objectives

- At the completion of this educational activity, the learner will be able to:
  - Provide an overview on 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 of Coding Clinic

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-10-CM/PCS
  - 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-10-CM/PCS

The AHA Central Office
Coding Clinic for ICD-10-CM/PCS

- In concert with Cooperating Parties, publishes the Coding Clinic for ICD-10-CM/PCS
  - CMS' affirmation of the Coding Clinic as the official source of coding information is noted in the Federal Register, Vol. 74, No. 165, Thursday, August 27, 2009 - https://tinyurl.com/ybxeq78h
  - 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
- In essence, the Supreme Court in coding issues
  - Used by the Department of Justice and HHS OIG in judging coding compliance
- Cod*ing 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

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

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

.

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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

Disease

Index

knee M12.16-
multiple site M12.19
shoulder M12.11-
vertebra M12.18
wrist M12.13-
Katayama B65.2
Kedani (scrub typhus) A75.3
Keshan E59
kidney (functional) (pelvis) N28.9
complicating pregnancy - see Pregnancy, complicated by, renal disease
chronic N18.9
hypertensive - see Hypertension, kidney
stage 1 N18.1
stage 2 (mild) N18.2
stage 3 (moderate) N18.3
stage 4 (severe) N18.4
stage 5 N18.5
cystic (congenital) Q61.9
diabetic - see E08-E13 with .22
fibrocystic (congenital) Q61.8
hypertensive - see Hypertension, kidney
in (due to)
schistosomiasis (bilharziasis) B65.9 [N29]
multicystic Q61.4
polycystic Q61.3
adult type Q61.2
childhood type NEC Q61.19
collecting duct dilatation Q61.11
Kimmelstiel(-Wilson) (intercapillary polycystic (congenital) glomerulosclerosis) - see E08-E13 with .21
Kimura D21.9
specified site - see also Neoplasm, connective tissue benign
Kinnier Wilson's (hepatolenticular degeneration) E83.01
kissing - see Mononucleosis, infectious
Klebs' (see also Glomerulonephritis) N05.-
Klippel-Feil (brevicollis) Q76.1
Köhler-Pellegrini-Stieda (calcification, knee joint) - see Bursitis, tibial collateral
Kok Q89.8
König's (osteochondritis dissecans) - see Osteochondritis, dissecans

Table

Category: N18 - Chronic kidney disease (CKD)

N18 Chronic kidney disease (CKD)

Code first any associated:
diabetic chronic kidney disease (E08.22, E09.22, E10.22, E11.22, E13.22)
hypertensive chronic kidney disease (I12.-, I13.-)
Use additional code to identify kidney transplant status, if applicable, (Z94.0)

N18.1 Chronic kidney disease, stage 1

N18.2 Chronic kidney disease, stage 2 (mild)

N18.3 Chronic kidney disease, stage 3 (moderate)

N18.4 Chronic kidney disease, stage 4 (severe)

N18.5 Chronic kidney disease, stage 5

EXCLUDES 1
chronic kidney disease, stage 5 requiring chronic dialysis (N18.6)

N18.6 End stage renal disease

Chronic kidney disease requiring chronic dialysis
Use additional code to identify dialysis status (Z99.2)

N18.9 Chronic kidney disease, unspecified

Chronic renal disease
Chronic renal failure NOS
Chronic renal insufficiency
Chronic uremia
Renal disease NOS

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

Ascites (abdominal) R18.8
- cardiac -*see also* Failure, heart, right I50.810
- chylous (nonfilarial) I89.8
- - filarial -*see* Infestation, filarial
- due to
- - cirrhosis, alcoholic K70.31
- - hepatitis
- - - alcoholic K70.11
- - - chronic active K71.51
- - S. japonicum B65.2
- heart -*see also* Failure, heart, right I50.810
- malignant R18.0
- pseudochylous R18.8
- syphilitic A52.74
- tuberculous A18.31

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 2019

(October 1, 2018 - September 30, 2019)

Narrative changes appear in bold text
Items underlined have been moved within the guidelines since the FY 2018 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).

- An essential reference that must be read over and over and over again. Available for free at:
- http://www.tinyurl.com/2019ICD10CMguidelines

2018 ICD-10-CM Official Guidelines
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.**

P74 Other transitory neonatal electrolyte and metabolic disturbances

P74.0 Late metabolic acidosis of newborn

Excludes1: (fetal) metabolic acidosis of newborn (P19)

P74.1 Dehydration of newborn

P74.2 Disturbances of sodium balance of newborn

P74.3 Disturbances of potassium balance of newborn

P74.4 Other transitory electrolyte disturbances of newborn

P74.5 Transitory tyrosinemia of newborn

P74.6 Transitory hyperammonemia of newborn

P74.8 Other transitory metabolic disturbances of newborn
Amino-acid metabolic disorders described as transitory

P74.9 Transitory metabolic disturbance of newborn, unspecified

Chapter 16 Excludes2 Notes
Includes E00-E88, Endocrine/Nutritional/Met. Diseases

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Chapter 16

Certain conditions originating in the perinatal period (P00-P96)

Note: Codes from this chapter are for use on newborn records only, never on maternal records

Includes: conditions that have their origin in the fetal or perinatal period (before birth through the first 28 days after birth) even if morbidity occurs later

Excludes2: congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)
endocrine, nutritional and metabolic diseases (E00-E88)
injury, poisoning and certain other consequences of external causes (S00-T88)
neoplasms (C00-D49)
tetanus neonatorum (A33)

b. Excludes2

A type 2 Excludes note represents "Not included here." An excludes2 note indicates that the condition excluded is not part of the condition represented by the code, but a patient may have both conditions at the same time. When an Excludes2 note appears under a code, it is acceptable to use both the code and the excluded code together, when appropriate.

Chapter 4

Endocrine, nutritional and metabolic diseases (E00-E89)

Note: All neoplasms, whether functionally active or not, are classified in Chapter 2. Appropriate codes in this chapter (i.e. E05.8, E07.0, E16-E31, E34.-) may be used as additional codes to indicate either functional activity by neoplasms and ectopic endocrine tissue or hyperfunction and hypofunction of endocrine glands associated with neoplasms and other conditions classified elsewhere.

Excludes1: transitory endocrine and metabolic disorders specific to newborn (P70-P74)

This chapter contains the following blocks:

E00-E07	Disorders of thyroid gland
E08-E13	Diabetes mellitus
E15-E16	Other disorders of glucose regulation and pancreatic internal secretion
E20-E35	Disorders of other endocrine glands
E36	Intraoperative complications of endocrine system
E40-E46	Malnutrition
E50-E64	Other nutritional deficiencies
E65-E68	Overweight, obesity and other hyperalimentation
E70-E88	Metabolic disorders
E89	Postprocedural endocrine and metabolic complications and disorders, not elsewhere classified

a. 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.

Notice the conflict between these Excludes1 and Excludes2 notes

Coding Clinic 2nd Q 2018, p.6
Neonatal Sodium Disorders

- **Question:** Please clarify the appropriate code assignment for an infant in the perinatal period, who develops either hyponatremia or hypernatremia.
  - There is an Excludes2 note at the beginning of Chapter 16, Certain conditions originating in the Perinatal Period (P00-P96), indicating these codes can be assigned with a code from Chapter 4, Endocrine, nutritional and metabolic disease (E00-E89).
  - However, at the beginning of Chapter 4 there is an Excludes1 note that does not allow assigning codes in categories E00-E89 with codes in categories P70-P74.
- Based on these conflicting Excludes notes, would code P74.2, Disturbances of sodium balance of newborn, be assigned with either code E87.0, Hyperosmolality and hypernatremia, or code E87.1, Hypo-osmolality and hyponatremia, to further specify the condition?

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Coding Clinic 2nd Q 2018, p.6
Neonatal Sodium Disorders

- **Answer:** Assign **only** code P74.2, Disturbances of sodium balance of newborn, when the newborn is diagnosed with a disturbance of sodium balance, such as hypernatremia or hyponatremia.

Take home lessons

- If there are conflicting Excludes1 and Excludes2 notes, the Excludes1 note trumps the Excludes2 note

New ICD-10-CM Codes Effective October 1, 2018

No Change **P74 Other transitory neonatal electrolyte and metabolic disturbances**

No Change **P74.2 Disturbances of sodium balance of newborn**

Add **P74.21 Hypernatremia of newborn**

Add **P74.22 Hyponatremia of newborn**

No Change **P74.3 Disturbances of potassium balance of newborn**

Add **P74.31 Hyperkalemia of newborn**

Add **P74.32 Hypokalemia of newborn**

No Change **P74.4 Other transitory electrolyte disturbances of newborn**

Add **P74.41 Alkalosis of newborn**
Add Hyperbicarbonatemia

Add **P74.42 Disturbances of chlorine balance of newborn**

Add **P74.421 Hyperchloremia of newborn**
Add Hyperchloremic metabolic acidosis

Add **Excludes2:** late metabolic acidosis of the newborn (P77.0)

Add **P74.422 Hypochloremia of newborn**

Add **P74.49 Other transitory electrolyte disturbance of newborn**

2018 ICD-10-CM Official Guidelines
The word "With" or "In"

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- "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").**

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Sepsis "with" organ dysfunction

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

Sepsis (generalized) (unspecified organism) A41.9
- with
- - organ dysfunction (acute) (multiple) R65.20
- - - with septic shock R65.21

R65.2 **Severe sepsis**
Infection with associated acute organ dysfunction
Sepsis with acute organ dysfunction
Sepsis with multiple organ dysfunction
Systemic inflammatory response syndrome due to infectious process with acute organ dysfunction

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

ICD-10-PCS Root Operation Fusion

Fusion: ***Joining*** together portions of an articular body part rendering the articular body part immobile

Section	**0**	Medical and Surgical
Body System	**R**	Upper Joints
Operation	**G**	Fusion: Joining together portions of an articular body part rendering the articular body part immobile

Body Part	*Approach*	*Device*	*Qualifier*
0 Occipital-cervical Joint **1** Cervical Vertebral Joint **2** Cervical Vertebral Joints, 2 or more **4** Cervicothoracic Vertebral Joint **6** Thoracic Vertebral Joint **7** Thoracic Vertebral Joints, 2 to 7 **8** Thoracic Vertebral Joints, 8 or more **A** Thoracolumbar Vertebral Joint	**0** Open **3** Percutaneous **4** Percutaneous Endoscopic	**7** Autologous Tissue Substitute **J** Synthetic Substitute **K** Nonautologous Tissue Substitute **Z** No Device	**0** Anterior Approach, Anterior Column **1** Posterior Approach, Posterior Column **J** Posterior Approach, Anterior Column
0 Occipital-cervical Joint **1** Cervical Vertebral Joint **2** Cervical Vertebral Joints, 2 or more **4** Cervicothoracic Vertebral Joint	**0** Open **3** Percutaneous **4** Percutaneous Endoscopic	**A** Interbody Fusion Device	**0** Anterior Approach, Anterior Column **J** Posterior Approach, Anterior Column

Spinal Fusion
CC, 2nd Quarter, 2017, pages 23-24

The health record documentation states that the patient underwent laminectomy C3 through C7, decompression of the spinal cord, **placement of posterior instrumentation and spinal fusion**, due to cervical spondylosis.

- After decompression of the spinal cord, lateral mass screws were placed from C3-C6 bilaterally with connecting rods.

Questions:

- Would placement of instrumentation be coded as a pedicle based stabilization device?
- **What device value is assigned for the spinal fusion?**
- Would the decompression of the spinal cord be coded separately or is it considered inherent to the total surgery?

Spinal Fusion
CC, 2nd Quarter, 2017, pages 23-24

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- **In this case, a spinal fusion was not carried out.**
  - There was no documentation of bone graft or a bone graft substitute being utilized; only spinal cord decompression and insertion of rods and screws (instrumentation) were accomplished.
- Instrumentation alone does not constitute a spinal fusion.
  - Spinal fusion involves the use of bone graft or bone graft substitute, which can be done with or without instrumentation.
- Further, the insertion of rods and screws is not the same as the placement of a pedicle based stabilization device.

Spinal Fusion
CC, 1st Quarter, 2018, pages 23-24

- Question: This advice of CC 2017, 2nd Quarter, appears to conflict with the root operation explanation, which states, “The body part is joined together by fixation device, bone graft, or other means.” Could you provide an explanation?
- Answer: The previously published advice is accurate.
  - There is no discrepancy in the case of spinal fusion, because there is a specific guideline for spinal fusion that goes beyond the basic root operation definition of “Fusion.”
  - While the root operation of “fusion” does not require the use of bone graft, the spinal fusion guideline indicates that a spinal fusion requires bone graft.

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2018 and 2019 ICD-10-PCS Official Guidelines

Fusion procedures of the spine

B3.10a

The body part coded for a spinal vertebral joint(s) rendered immobile by a spinal fusion procedure is classified by the level of the spine (e.g. thoracic). There are distinct body part values for a single vertebral joint and for multiple vertebral joints at each spinal level.

Example: Body part values specify Lumbar Vertebral Joint, Lumbar Vertebral Joints, 2 or More and Lumbosacral Vertebral Joint.

B3.10b

If multiple vertebral joints are fused, a separate procedure is coded for each vertebral joint that uses a different device and/or qualifier.

Example: Fusion of lumbar vertebral joint, posterior approach, anterior column and fusion of lumbar vertebral joint, posterior approach, posterior column are coded separately.

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2018 and 2019 ICD-10-PCS Official Guidelines

B3.10c

Combinations of devices and materials are often used on a vertebral joint to render the joint immobile. When combinations of devices are used on the same vertebral joint, the device value coded for the procedure is as follows:

- If an interbody fusion device is used to render the joint immobile (alone or containing other material like bone graft), the procedure is coded with the device value Interbody Fusion Device
- If bone graft is the *only* device used to render the joint immobile, the procedure is coded with the device value Nonautologous Tissue Substitute or Autologous Tissue Substitute
- If a mixture of autologous and nonautologous bone graft (with or without biological or synthetic extenders or binders) is used to render the joint immobile,

Examples: Fusion of a vertebral joint using a cage style interbody fusion device containing morsellized bone graft is coded to the device Interbody Fusion Device.
Fusion of a vertebral joint using a bone dowel interbody fusion device made of cadaver bone and packed with a mixture of local morsellized bone and demineralized bone matrix is coded to the device Interbody Fusion Device.
Fusion of a vertebral joint using both autologous bone graft and bone bank bone graft is coded to the device Autologous Tissue Substitute.

Questions Sent To Coding Clinic About ICD-10-PCS Guidelines

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eview Submission / Check Status

Status

Open
The question has been successfully submitted, but not yet assigned for review

Your Information

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Question Type

ICD-10-PCS

Question Title

Spinal Fusion - Requirement for bone grafting

Your Question

Can you explicitly point out to me where in the ICD-10-PCS guidelines that it states that a bone graft is required in a spinal fusion? B10.C states that an interbody fusion device without grafting can be used to render the joint mobile. Thank you.

Spinal Fusion Procedure Codes Deleted Due To Lack of Device Codes

ICD-10-PCS	Code Description
0RG00Z0	Fusion of Occipital-cervical Joint, Anterior Approach, Anterior Column, Open Approach
0RG00Z1	Fusion of Occipital-cervical Joint, Posterior Approach, Posterior Column, Open Approach
0RG00ZJ	Fusion of Occipital-cervical Joint, Posterior Approach, Anterior Column, Open Approach
0RG03Z0	Fusion of Occipital-cervical Joint, Anterior Approach, Anterior Column, Percutaneous Approach
0RG03Z1	Fusion of Occipital-cervical Joint, Posterior Approach, Posterior Column, Percutaneous Approach
0RG03ZJ	Fusion of Occipital-cervical Joint, Posterior Approach, Anterior Column, Percutaneous Approach
0RG04Z0	Fusion of Occipital-cervical Joint, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG04Z1	Fusion of Occipital-cervical Joint, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RG04ZJ	Fusion of Occipital-cervical Joint, Posterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG10Z0	Fusion of Cervical Vertebral Joint, Anterior Approach, Anterior Column, Open Approach
0RG10Z1	Fusion of Cervical Vertebral Joint, Posterior Approach, Posterior Column, Open Approach
0RG10ZJ	Fusion of Cervical Vertebral Joint, Posterior Approach, Anterior Column, Open Approach
0RG13Z0	Fusion of Cervical Vertebral Joint, Anterior Approach, Anterior Column, Percutaneous Approach

High Prevalence of Invalid Spinal Fusion Codes

Summary Table for Spinal Fusion Procedures			
MS-DRG	Number of Cases	Average Length of Stay	Average Costs
MS-DRGs 028, 029, 030, 453, 454, 455, 456, 457, 458, 459, 460, 471, 472, and 473--All cases	142,752	3.9	$31,788
MS-DRGs 028, 029, 030, 453, 454, 455, 456, 457, 458, 459, 460, 471, 472, and 473--Cases with invalid spinal fusion procedures	16,472	5.1	$42,929

Given Coding Clinic's and Medicare's emphasis on spinal fusions, the speaker believes that inpatient coding practices for spinal fusions must be addressed, particularly regarding the use of bone grafting

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

Photo credit: Wikipedia
http://en.wikipedia.org/wiki/Bridge

COPD and Asthma

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COPD – Asthma Overlap Syndrome

Diagnosis of Diseases of Chronic Airflow Limitation:

Asthma COPD and Asthma - COPD Overlap Syndrome (ACOS)

ALTER OR REPRODUCE

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

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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.

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Coding Clinic, 1st Quarter, 2017, page 25

- **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 necessary 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

	MS-DRG	APR-DRG
Exacerbated COPD Asthma	MS-DRG 192 COPD w/o CC/MCC 0.7265	APR DRG 140 COPD SOI 1 (0.493) ROM 1
Exacerbated COPD A specified type of asthma (e.g. mild intermittent)	MS-DRG 192 COPD w/o CC/MCC 0.7265	APR DRG 140 COPD SOI 1 (0.493) ROM 1
Exacerbated COPD (PDx) Exacerbated Asthma	MS-DRG 191 COPD w/CC 0.9176	APR DRG 140 COPD SOI 2 (0.6227) ROM 1
Exacerbated COPD (PDx) Exacerbated specific type of asthma	MS-DRG 191 COPD w/CC 0.9176	APR DRG 140 COPD SOI 2 (0.6227) ROM 1
Exacerbated Asthma (PDx) Exacerbated COPD	MS-DRG 202 Asthma w/CC/MCC 0.9260	APR DRG 141 Asthma SOI 2 (0.5467) ROM 1

Exacerbation of COPD in the Setting of Emphysema

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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

COPD is APR-DRG SOI of 2

COPD is MS-DRG CC only if decompensated

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

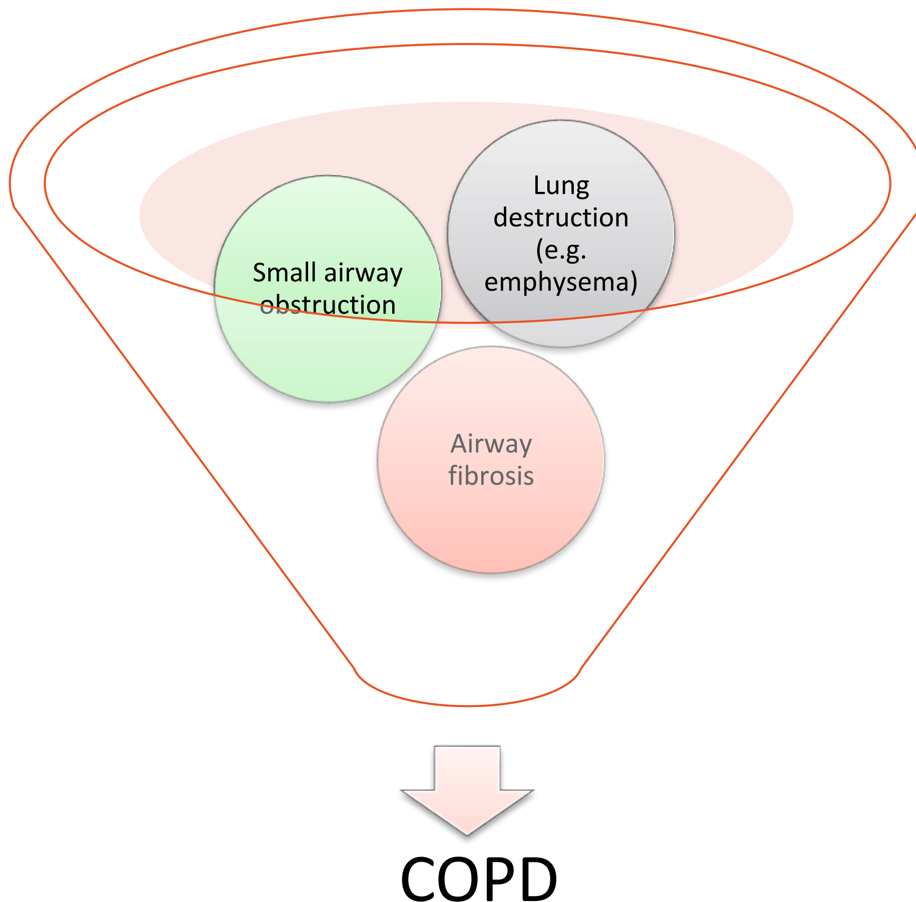
unilateral J43.0

Note there is no code for "decompensated emphysema"

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!

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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.

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Encephalopathy

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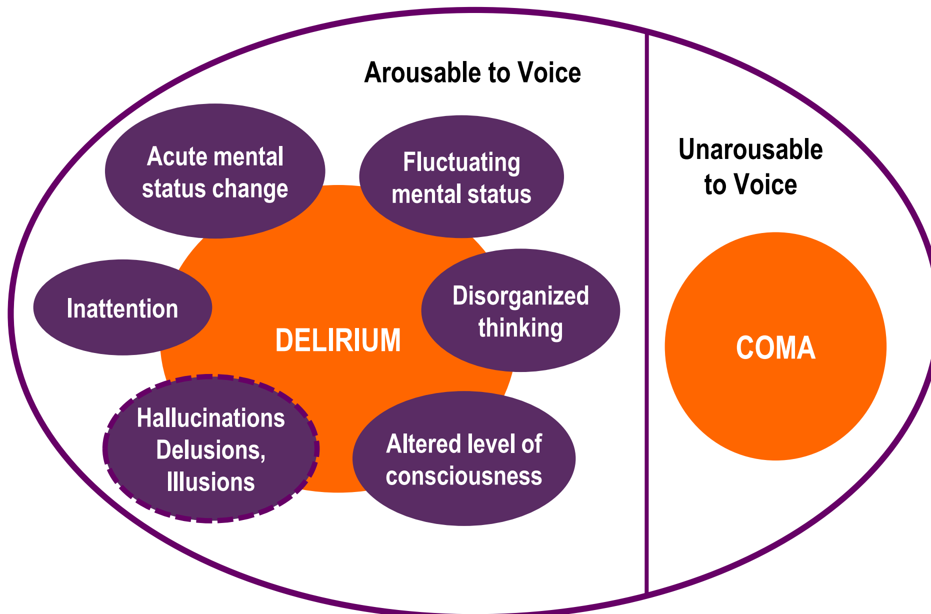
MDC 1 – Encephalopathy
Global Disease or Dysfunction

- 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

Delirium vs. 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 personal 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.

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
- - metabolic 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

Coding Clinic, 2nd Q, 2017, pp 8-9

Question:
A patient is admitted to the hospital due to altered mental status, and is diagnosed with an acute lacunar infarct and encephalopathy secondary to the lacunar infarction. Would the encephalopathy be coded separately or is it considered inherent to the acute lacunar infarct?

Answer:
Assign code G93.49, Other encephalopathy, for encephalopathy that occurs secondary to an acute cerebrovascular accident/stroke. Although the encephalopathy is associated with an acute lacunar infarct, it is not inherent, and therefore is coded when it occurs.

- Dr. Kennedy disagreed with this advice and registered his complaint to the Coding Clinic

ICD-10-CM Guidelines
B. General Coding Guidelines

- 5. Conditions that are an integral part of a disease process
  - Signs and symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the classification.
- 6. Conditions that are not an integral part of a disease process
  - Additional signs and symptoms that may not be associated routinely with a disease process should be coded when present.

Clarification
Coding Clinic, 2nd Quarter, 2018

- **Question:** *Coding Clinic* Second Quarter 2017, pages 8-9, G93.49, Other encephalopathy, was assigned for encephalopathy secondary to an acute stroke.
  - Please clarify the appropriate code assignment for encephalopathy when it is caused by some other condition and the encephalopathy is not specified.
- **Answer:** The advice provided in *Coding Clinic* Second Quarter 2017, pages 8-9 is accurate.
  - When encephalopathy is linked to a specific condition, such as stroke or urinary tract infection, it is appropriate to use the code describing "other encephalopathy."
  - Therefore, assign code G93.49, Other encephalopathy, when encephalopathy is linked to a condition, but a specific encephalopathy (e.g., metabolic, toxic, hypertensive, etc.) is not documented.

(Acute) Encephalopathy "in" a Disease (e.g. UTI) Not Classified In the Index

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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

} A MCC

G94 Other disorders of brain in diseases classified elsewhere

NOT A MCC

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)

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

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]

One has to pay special attention to the encephalopathy in hyperinsulinism and posthypoglycemic encephalopathy

- 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]

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

Toxic Encephalopathy
Clinical versus Coding Definitions

Clinical Definition

- **Brain dysfunction caused by toxic exposure**

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

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
- toxic G92
- - metabolic G92
Jamaican
- neuropathy G92
Leukoencephalopathy -see also Encephalopathy G93.49
- Binswanger's I67.3
- heroin vapor G92

Kim Y, Kim JW. Toxic Encephalopathy. Saf Health Work. 2012 Dec; 3(4): 243–256
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 2^0 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 2⁰ Lithium OD

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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.

Coding Clinic, 1st Quarter, 2017, page 40

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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**

Diabetes or Other Conditions "With" or "In" NEC Diseases

The Words “With” or “In” When Used in the Index or Table

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“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”).**

Not Elsewhere Classifiable (NEC) vs. Not Otherwise Specified (NOS)

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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

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NEC in Association with "With" and "In"
Coding Clinic, 2nd Quarter, 2018, page 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."

Diabetes With Cellulitis
Coding Clinic, 4th Quarter, 2017, pp 100-101

- 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?

Diabetes With Cellulitis
Coding Clinic, 4th Quarter, 2017, pp 100-101

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- **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.

Diabetic Peripheral Angiopathy

Diabetes

- **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

Notice how peripheral angiopathy does NOT have a NEC classification

- - 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

Coding Clinic 2nd Q 2018, p.7
Diabetes and Peripheral Atherosclerosis

- **Question:** The ICD-10-CM provides a combination code for diabetes with peripheral angiopathy.
  - Coding professionals would like to know what constitutes "diabetic peripheral angiopathy" and if peripheral arteriosclerosis or peripheral vascular disease in a diabetic patient is considered peripheral angiopathy?
- **Answer:** Yes, peripheral arteriosclerosis is a type of angiopathy.
  - Peripheral arteriosclerosis, peripheral vascular disease and peripheral arterial disease in a diabetic patient should be linked and coded as "diabetic peripheral angiopathy."

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Atherosclerosis

Atheromatosis -*see* Arteriosclerosis
Atherosclerosis -*see also* Arteriosclerosis
- coronary
- - artery I25.10
- - - with angina pectoris -*see* Arteriosclerosis, coronary (artery),
- - - due to
- - - - calcified coronary lesion (severely) I25.84
- - - - lipid rich plaque I25.83
- transplanted heart I25.811
- - bypass graft I25.812
- - - with angina pectoris -*see* Arteriosclerosis, coronary (artery),
- - native coronary artery I25.811
- - - with angina pectoris -*see* Arteriosclerosis, coronary (artery),

Arteriosclerosis

Arteriosclerosis, arteriosclerotic (diffuse) (obliterans) (of) (senile) (with calcification) I70.90
- aorta I70.0
- arteries of extremities -*see* Arteriosclerosis, extremities
- brain I67.2
- bypass graft
- - coronary -*see* Arteriosclerosis, coronary, bypass graft
- - extremities -*see* Arteriosclerosis, extremities, bypass graft
- cardiac -*see* Disease, heart, ischemic, atherosclerotic
- cardiopathy -*see* Disease, heart, ischemic, atherosclerotic
- cardiorenal -*see* Hypertension, cardiorenal
- cardiovascular -*see* Disease, heart, ischemic, atherosclerotic
- carotid -*see also* Occlusion, artery, carotid I65.2-
- central nervous system I67.2
- cerebral I67.2
- cerebrovascular I67.2

The ICD-10-CM Index has a whole host of peripheral vascular diseases.

Dr. Kennedy's personal opinion: Coronary artery disease is clinically not "peripheral vascular", thus should not be included in this Coding Clinic concept

For E(09-13).51 and Arteriosclerosis Codes No "Code First" or "Use Additional Code" Instruction

E11.5 Type 2 diabetes mellitus with circulatory complications

E11.51 Type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene

E11.52 Type 2 diabetes mellitus with diabetic peripheral angiopathy with gangrene
Type 2 diabetes mellitus with diabetic gangrene

E11.59 Type 2 diabetes mellitus with other circulatory complications

I65 Occlusion and stenosis of precerebral arteries, not resulting in cerebral infarction

Includes: embolism of precerebral artery
narrowing of precerebral artery
obstruction (complete) (partial) of precerebral artery
thrombosis of precerebral artery

Excludes1: insufficiency, NOS, of precerebral artery (G45.-)
insufficiency of precerebral arteries causing cerebral infarction (I63.0-I63.2)

I65.0 Occlusion and stenosis of vertebral artery

I65.01 Occlusion and stenosis of right vertebral artery

I65.02 Occlusion and stenosis of left vertebral artery

DRG Impact of Adding E11.51 Carotid Endarterectomy

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Medicare DRG and MDC Information

039	EXTRACRANIAL PROCEDURES W/O CC/MCC CMS wt 1.1137 A/LOS 1.5 G/LOS 1.3
001	DISEASES & DISORDERS OF THE NERVOUS SYSTEM

APR (all versions) DRG and MDC Information

024	EXTRACRANIAL VASCULAR PROC APR wt 1.4944 Low Trim 1 High Trim 12 ALOS 1.97 GLOS 1.56 Status: LOS Inlier
001	NERVOUS SYSTEM
2	Moderate Severity of Illness
1	Minor Risk of Mortality

Admit Diagnosis

Code	Description
J189	Pneumonia, unspecified organism

Diagnosis Code Detail

Code	Description	Affect	MCC	CC	SOI	ROM	Sort
I6522	Principal Occlusion and stenosis of left carotid artery	✓			P	P	
E1151	Type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene				2	2	

Procedure Code Detail

Code	Description	Affect	SP
03CL0ZZ	Principal Extirpation of Matter from Left Internal Carotid Artery, Open Approach	✓	
03UL0KZ	Supplement Left Internal Carotid Artery with Nonautologous Tissue Substitute, Open Approach		

- No impact on MS-DRG
- Moves SOI from a 1 to a 2 in APR-DRGs

TIA with Carotid Stenosis

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Occlusion and Stenosis of Precerebral Arteries Not Resulting in Cerebral Infarction

I65 Occlusion and stenosis of precerebral arteries, not resulting in cerebral infarction

Includes: embolism of precerebral artery
narrowing of precerebral artery
obstruction (complete) (partial) of precerebral artery
thrombosis of precerebral artery

Excludes1: insufficiency, NOS, of precerebral artery (G45.-)
insufficiency of precerebral arteries causing cerebral infarction (I63.0-I63.2)

I65.0 Occlusion and stenosis of vertebral artery

I65.01 Occlusion and stenosis of right vertebral artery

I65.02 Occlusion and stenosis of left vertebral artery

I65.03 Occlusion and stenosis of bilateral vertebral arteries

I65.09 Occlusion and stenosis of unspecified vertebral artery

I65.1 Occlusion and stenosis of basilar artery

I65.2 Occlusion and stenosis of carotid artery

I65.21 Occlusion and stenosis of right carotid artery

I65.22 Occlusion and stenosis of left carotid artery

I65.23 Occlusion and stenosis of bilateral carotid arteries

I65.29 Occlusion and stenosis of unspecified carotid artery

I65.8 Occlusion and stenosis of other precerebral arteries

I65.9 Occlusion and stenosis of unspecified precerebral artery
Occlusion and stenosis of precerebral artery NOS

Note the Excludes1 note for G45.- and for I63.0-I63.2

G45 Codes Excluded

G45 Transient cerebral ischemic attacks and related syndromes

Excludes1: neonatal cerebral ischemia (P91.0)
transient retinal artery occlusion (H34.0-)

G45.0 Vertebro-basilar artery syndrome

G45.1 Carotid artery syndrome (hemispheric)

G45.2 Multiple and bilateral precerebral artery syndromes

G45.3 Amaurosis fugax

G45.4 Transient global amnesia

Excludes1: amnesia NOS (R41.3)

G45.8 Other transient cerebral ischemic attacks and related syndromes

G45.9 Transient cerebral ischemic attack, unspecified
Spasm of cerebral artery
TIA
Transient cerebral ischemia NOS

I63.0 – I63.2 Codes Excluded

I63 Cerebral infarction

Includes: occlusion and stenosis of cerebral and precerebral arteries, resulting in cerebral infarction

Use additional code, if applicable, to identify status post administration of tPA (rtPA) in a different facility within the last 24 hours prior to admission to current facility (Z92.82)

Use additional code, if known, to indicate National Institutes of Health Stroke Scale (NIHSS) score (R29.7-)

Excludes2: sequelae of cerebral infarction (I69.3-)

I63.0 Cerebral infarction due to thrombosis of precerebral arteries

I63.1 Cerebral infarction due to embolism of precerebral arteries

I63.2 Cerebral infarction due to unspecified occlusion or stenosis of precerebral arteries

- Note that I63.0-I63.2 includes only *precerebral* arteries (e.g. internal carotid or vertebral arteries)
- *NOT EXCLUDED*
  - I63.(3-5) – Cerebral infarction due to cerebral/cerebellar arteries
  - I63.6 – Cerebral infarction due to cerebral venous thrombosis
  - I63.8 – Other cerebral infarction
  - I63.9 – Cerebral infarction, not specified

Coding Clinic 2nd Q 2018, p.8
TIA in the Setting of Carotid Artery Stenosis

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- **Question:** A 73-year-old female presents due to intermittent episodes of balance and vision changes with right hemiparesis. She is diagnosed with transient ischemic attack (TIA) due to bilateral carotid artery stenosis, with left side symptomatic stenosis.
  - Left carotid endarterectomy with bovine patch angioplasty was performed.
  - There is an Excludes 1 note under category I65-, Occlusion and stenosis of precerebral arteries, not resulting in cerebral infarction, that prohibits the reporting of a code from this category with the TIA code.
- Would it be appropriate to assign codes for both the TIA and bilateral carotid artery stenosis?

Coding Clinic 2nd Q 2018, p.8
TIA in the Setting of Carotid Artery Stenosis

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- **Answer:** Assign only code I65.23, Occlusion and stenosis of bilateral carotid arteries, for this patient.
  - **Although the patient initially presented due to the TIA, after study the underlying condition that caused the TIA and symptoms was the bilateral carotid stenosis, which was treated with endarterectomy**.
- The Excludes1 note under category I65 prohibits assigning codes in category G45 (nonspecific precerebral artery insufficiency), because the cause of the insufficiency is clearly specified as carotid artery stenosis.

No DRG Impact Based On This Advice

Medicare DRG and MDC Information

039	EXTRACRANIAL PROCEDURES W/O CC/MCC
001	DISEASES & DISORDERS OF THE NERVOUS SYSTEM

APR (all versions) DRG and MDC Information

024	EXTRACRANIAL VASCULAR PROC
001	NERVOUS SYSTEM
1	Minor Severity of Illness
1	Minor Risk of Mortality

Admit Diagnosis

Code	Description
G459	Transient cerebral ischemic attack, unspecified

Diagnosis Code Detail

Code	Description	Affect	MCC	CC	SOI	ROM
I6522	Principal Occlusion and stenosis of left carotid artery	✓			P	P
G459	Transient cerebral ischemic attack, unspecified				X	X

Procedure Code Detail

Code	Description	Affect
03CL0ZZ	Principal Extirpation of Matter from Left Internal Carotid Artery, Open Approach	✓
03UL0KZ	Supplement Left Internal Carotid Artery with Nonautologous Tissue Substitute, Open Approach	

- Even if TIA was to be added, there is no impact on the MS-DRG or APR-DRG

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:

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- 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.

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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

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- 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

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- **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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