Best of AHA Coding Clinic for ICD-10-CM

Wednesday, June 18, 2014
12:00 – 1:00pm CST

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– Individually
– In a group of 2-5
– In a group of 6-10
– In a group of 11-20
– In a group of 21 or more

Overview

• Update on Coding Clinic Plans
• Clinical information from Coding Clinic
• Neurological deficits due to stroke
• Pneumonia and hemoptysis
• Status asthmaticus and acute exacerbation
• Decompensated heart failure
• Nicotine dependence, tobacco use vs. dependence
• Smoke inhalation and acute respiratory failure
• Degenerative disc disease

• Documentation issues from Coding Clinic
• Nonprovider documentation for external cause of morbidity
• Glasgow coma score
• Using x-rays for specificity
• Facility specific coding guidelines
• Diabetes mellitus and hyperglycemia
• Diabetes and ketoacidosis
• Diabetes and osteomyelitis
• Diabetic gastroparesis
• Admission for rehab
• Postoperative seroma
• Nonhealing surgical wound
How Does the ICD-10 Delay Affect Coding Clinic?

- AHA Central Office is NOT reverting back to accepting or publishing questions on ICD-9-CM.
- Coding Clinic will focus time and attention on ICD-10-CM and ICD-10-PCS to better address issues in advance of implementation and ensure a smoother ICD-10 transition.
Clinical Information from *Coding Clinic*

• What *Coding Clinic* is NOT
  – Clinical criteria for establishing diagnosis
    • *Coding Clinic* provides clinical “clues” not “criteria”
    • *Coding Clinic* has no authority to provide clinical definitions
  – Replacement for physician documentation
    • *Coding Clinic* may identify what documentation may be used for coding
    • *Coding Clinic* cannot arbitrate issues of clinical validity

Clinical Information from *Coding Clinic*? (cont.)

• All coding should be supported by provider documentation as defined by the Official Coding Guidelines.
  – Others may question whether clinical documentation supports a documented diagnosis, but *Coding Clinic* will provide codes for documented diagnoses.
Clinical Information from *Coding Clinic*? (cont.)

- *Coding Clinic* information may still be useful to understand clinical clues regarding signs or symptoms that may be integral (or not) to a condition.

- However, care should be exercised as ICD-10-CM has new combination codes as well as instructional notes that may or may not be consistent with ICD-9-CM.

What’s Not Changing – Clinical Information

- Signs and symptoms integral to a condition
  - Example:
    - Hypoxia is not inherent in COPD. When hypoxia is associated with COPD, it is appropriate to assign code 799.02, Hypoxemia, as an additional diagnosis if desired.

*Coding Clinic*, Third Quarter 2009, page 20
What’s Not Changing – Clinical Information (cont.)

• Signs and symptoms integral to a condition
  – Example:
    • Hemiplegia is not inherent to an acute cerebrovascular accident (CVA).
    • Therefore, it should be coded even if the hemiplegia resolves, with or without treatment.
    • The hemiplegia affects the care that the patient receives.
    • Report any neurological deficits caused by a CVA even when they have been resolved at the time of discharge from the hospital.

Pneumonia and Hemoptysis

• “Hemorrhagic” is not a non-essential modifier for pneumonia in ICD-10-CM Index
• Sequence pneumonia first
• Assign R04.2, Hemoptysis, as an additional code, if present
• Signs and symptoms may be reported when not routinely associated with the diagnosis
Acute Exacerbation of Asthma and Status Asthmaticus

• Every effort was made to carry over the ICD-9-CM guidelines and concepts into ICD-10-CM, unless there was a specific change in ICD-10-CM that precluded the incorporation of the same concept into ICD-10-CM.
  – However, some of the guidelines in ICD-9-CM included information that may have been clinical in nature (as in the example noted in the question) [Section I.C8.a.4, “Acute exacerbation of asthma and status asthmaticus] and therefore not appropriate for coding guidelines.

Coding Clinic, Fourth Quarter 2012, page 99

Acute Exacerbation of Asthma and Status Asthmaticus (cont.)

• Acute exacerbation of asthma and status asthmaticus (cont.)
  – With respect to the coding of acute exacerbation of asthma and status asthmaticus together, only the code for the more severe condition (i.e., status asthmaticus) should be assigned.

Coding Clinic, Fourth Quarter 2012, page 99
**Decompensated Heart Failure**

- Assign code I50.23, Acute on chronic systolic heart failure, for decompensated systolic heart failure.
- As previously stated, “decompensated” indicates that there has been a flare-up (acute phase) of a chronic condition.

_Coding Clinic, Second Quarter 2013, page 33_

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**Smoker (Tobacco Use vs. Dependence)**

- In ICD-10-CM “smoker” is classified to dependence
- Assign F17.200, Nicotine dependence, unspecified, uncomplicated
- Supported by Index:
  - **Smoker** — see Dependence, drug, nicotine

_Coding Clinic, Fourth Quarter 2013, page 108_
Nicotine Dependence

• Is there a definition or guideline for ICD-10-CM for
  – Uncomplicated?
  – In remission?
  – With withdrawal?
  – With other nicotine-induced disorders?
  – With unspecified nicotine-induced disorders?

Nicotine Dependence (cont.)

• Follow Official Guidelines for Coding and Reporting, Section I.C.5.c.
  – Applies to categories F10-F19
  – The appropriate codes for "in remission," "with withdrawal," etc., within categories F10-F19 are based on provider (as defined in the guidelines) documentation.

Coding Clinic, Fourth Quarter 2013, pages 108-109
Nicotine Dependence and Nicotine Induced Disorders

• Scenario: Cigarette smoker for 20+ years with COPD.
  – Can it be assumed COPD was caused by the cigarettes?
  – Assign code F17.218, Nicotine dependence, cigarettes, with other nicotine induced disorders?

Nicotine Dependence and Nicotine Induced Disorders (cont.)

• Do NOT assign code F17.218, unless there is provider documented cause and effect relationship.
  – Without documented linkage, assign codes J44.9, Chronic obstructive pulmonary disease, unspecified and F17.210, Nicotine dependence, cigarettes, uncomplicated.

*Coding Clinic, Fourth Quarter 2013, page 209*
Smoke Inhalation and Acute Respiratory Failure

- Scenario: Patient admitted through emergency department for smoke inhalation with acute respiratory failure.
  - Principal: J96.00, Acute respiratory failure, unspecified whether with hypoxia or hypercapnia
  - Secondary: T59.811A, Toxic effect of smoke, accidental (unintentional), Initial encounter, and code J70.5, Respiratory conditions due to smoke inhalation

Degenerative Disc Disease

- Currently, ICD-10-CM does not provide a code for unspecified degenerative disc disease. Query the provider for clarification regarding the affected region.
  - The National Center for Health Statistics (NCHS) is aware of the discrepancies in the index and has agreed to review and correct the index entries.

*Coding Clinic, Third Quarter 2013, page 22*
Gretchen Young-Charles, RHIA
Senior Coding Consultant

Coding Clinic Documentation

• Coding Clinic advice regarding documentation issues over the years has focused on what documentation can be used and was not specific to a coding system.

Coding Clinic for ICD-10-CM and ICD-10-PCS, First Quarter 2014
What’s Not Changing – Documentation Issues

• Associated Conditions and Documentation of a Linkage
  – It is not required that two conditions be listed together in the health record.
    • Linkage must be documented
    • Exception: classification assumes an association
  – When linkage or relationship is established between the two conditions, they should be coded as such.

What’s Not Changing – Documentation Issues (cont.)

• Associated Conditions and Documentation of a Linkage (cont.)
  – Review the entire record
  – The fact that a patient has two conditions that commonly occur together does not necessarily mean they are related.

Coding Clinic, Third Quarter 2012, page 3
Coding Clinic for ICD-10-CM and ICD-10-PCS, First Quarter 2014, page 15
What’s Not Changing – Documentation Issues (cont.)

• Cancer staging
  – It is appropriate to use the completed cancer staging form for coding purposes when it is authenticated by the attending physician?

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  Coding Clinic, Second Quarter 2010, pages 7-8
  Coding Clinic for ICD-10-CM and ICD-10-PCS, First Quarter 2014, page 12

What’s Not Changing – Documentation Issues (cont.)

• Mid-Level Provider Documentation
  – Appropriate to use documentation of other providers
    • nurse practitioners
    • physician assistants
  – Provider: the individual legally accountable for establishing a diagnosis

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  Coding Clinic, Fourth Quarter 2004, page 138
  Coding Clinic for ICD-10-CM and ICD-10-PCS, First Quarter 2014, page 12
What’s Not Changing – Documentation Issues (cont.)

• Documentation Discrepancy for Gestational Age
  – Based on the attending provider’s (e.g., pediatrician) documentation.
  – Different providers (e.g., obstetrician and pediatrician) may utilize different criteria.

  *Coding Clinic, First Quarter 2009, page 12*

Non-physician Documentation – External Cause Codes

• Based on physician documentation
  – If not documented, coders may use documentation available from non-physicians.
  – If there is conflict, the physician’s documentation takes precedence.

  *Coding Clinic for ICD-10-CM and ICD-10-PCS, First Quarter 2014, page 19*
Non-physician Documentation – Glasgow Coma Score

- Used in conjunction with traumatic brain injury (TBI)
- Emergency medical technician (EMT) may document patient’s initial GCS score in the field
  - Pre-hospital report containing the EMT’s documentation
  - Other non-physician documentation to determine the Glasgow coma score

Coding on the Basis of Up or Down Arrows

- Do not code on the basis of up and down arrows
  - Variable interpretations
  - Indicating change
  - Query provider regarding meaning
  - Applies for both inpatient and outpatient admissions
Using the X-ray for Specificity

• If the x-ray report provides additional information regarding the site for a condition that the provider has already diagnosed, it would be appropriate to assign a code to identify the specificity that is documented in the x-ray report.

Using the X-ray for Specificity – Inpatient

• Abnormal findings
• Findings outside the normal range and other tests ordered to evaluate the condition or prescribed treatment.
Using the X-ray for Specificity – Outpatient

- Diagnostic tests that have been interpreted and final report is available
- Related signs and symptoms

*Coding Clinic, First Quarter 2013, pages 28-29*

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Facility-Specific Coding Guidelines

- Should not replace physician documentation
  - Can guide when to query physicians for clarification, but not interpret abnormal findings or replace physician documentation or query.
  - Must be applied consistently to all records coded.
  - Must not conflict with Official Guidelines.

*Coding Clinic for ICD-10-CM and ICD-10-PCS, First Quarter 2014, pages 15-16*
New Advice for ICD-10-CM: Assigning Codes Using Prior Encounters

- Diagnoses that are current and relevant for that encounter should be clearly reflected.
- Conditions documented on previous encounters may not be clinically relevant on the current encounter.
- Historical problem list.
- Physician’s responsibility to document current applicable diagnoses.

Assigning Codes Using Prior Encounters (cont.)

- Recurring conditions must be documented on current admission.
- Conditions not documented in the current health record need physician confirmation.

Coding Clinic, Third Quarter 2013 pages 27-28
Hyperglycemia in Diabetes

• Two specific types of hyperglycemia:
  – Fasting hyperglycemia
  – Postprandial or after-meal hyperglycemia
• Complications of severely elevated glucose levels in diabetes:
  • Ketoacidosis (often affects type 1 diabetics)
  • Hyperglycemic hyperosmolar nonketotic syndrome (frequently seen in type 2 diabetics)
Hyperglycemia in Diabetes (cont.)

- ICD-10-CM no longer classifies diabetes as “controlled” or “uncontrolled”
  - Instructional notes in the Index under Diabetes, diabetic, inadequately controlled, out of control and/or poorly controlled direct:
    - “Code to Diabetes, by type, with hyperglycemia”

Type 2 Diabetic Retinopathy with Hyperglycemia

- Scenario: A patient with diabetic retinopathy presents with hyperglycemia. Can more than one diabetic code be assigned?
  - Any combination of the diabetes codes can be assigned together, unless one diabetic condition is inherent in another.
  - Codes E11.319, Type 2 diabetes mellitus with unspecified diabetic retinopathy without macular edema, and E11.65, Type 2 diabetes mellitus with hyperglycemia, are assigned.

*Coding Clinic, Third Quarter 2013, page 20*
Diabetic Ketoacidosis

- Life-threatening complication of diabetes occurring when the body produces high levels of ketones (blood acids)
  - Commonly affects patients with type 1 diabetes mellitus
  - Ketoacidosis signifies uncontrolled diabetes (hyperglycemia)
  - An additional diabetic code for hyperglycemia is not assigned
  - Assign code E10.10, Type 1 diabetes mellitus with ketoacidosis without coma

Diabetes Mellitus Type 2 with Ketoacidosis

- Diabetic ketoacidosis commonly affects type 1 diabetics
- However can affect type 2 diabetics
- Currently ICD-10-CM does not provide a specific code for type 2 diabetic ketoacidosis
- Assign code E13.10, Other specified diabetes mellitus with ketoacidosis without coma
- Clinically more important to identify the fact that the patient has ketoacidosis
Diabetes and Osteomyelitis

- ICD-9-CM assumes a relationship between diabetes and osteomyelitis when both conditions are present
  - Unless the physician documentation indicates the osteomyelitis is unrelated to the diabetes
- ICD-10-CM does NOT presume a linkage between diabetes and osteomyelitis
- Physician will need to document a linkage/relationship in order to code as such

*Coding Clinic, Fourth Quarter 2013, page 114*

Diabetes Gastroparesis

- Diabetic gastroparesis is caused by damage to the vagus nerve
- In ICD-10-CM “diabetes mellitus with diabetic gastroparesis” are inclusion terms under the diabetes codes (E08.43, E09.43, E10.43, E11.43, and E13.43)
- Code titles are not specific for diabetic gastroparesis
- Assign an additional code to identify the manifestation as gastroparesis:
  - E11.43 Type 2 diabetes mellitus with diabetic autonomic (poly) neuropathy
  - K31.84, Gastroparesis

*Coding Clinic, Fourth Quarter 2013, pages 114-115*
Rehabilitation

- Guideline Section II. Selection of Principal Diagnosis:
  - Admission/encounter is for rehabilitation, what is the condition requiring rehab? No counterpart to ICD-9-CM category V57
    - Sequence first the code for condition for services performed.
      - Example: Rehab for right-sided dominant hemiplegia following CVA, report code I69.351, Hemiplegia and hemiparesis, following cerebral infarction affecting right dominant side.
    - If condition no longer present, report first the appropriate aftercare code.
      - Example: Severe degenerative osteoarthritis of hip, had hip replacement and now encounter for rehab. Report code Z47.1, Aftercare following joint replacement surgery.

Coding Clinic Example of Rehab Stay for Fracture Aftercare

- Scenario:
  - Patient admitted for an inpatient rehab stay following surgical treatment of a displaced fracture of the right intertrochanteric femur. During the stay, the patient received physical and occupational therapy and fracture aftercare.
  - Assign code S72.141D, Displaced intertrochanteric fracture of right femur, subsequent encounter
Postoperative Seroma

• An accumulation of clear bodily fluids in an area where tissue has been surgically removed
• ICD-10-CM directs the coder to see “hematoma” under “seroma”
• The specific code assignment depends on the body system involved in the surgery
• Code assignment based on a particular type of procedure such as seroma following a cardiac bypass, cardiac catheterization or other circulatory system procedure
• Assign codes in subcategory I97.6-, Postprocedural hemorrhage and hematoma of a circulatory system organ or structure following a procedure

Nonhealing Surgical Wound

• Occurs when a surgical incision (wound) does not heal normally
• ICD-10-CM does not provide a specific code for nonhealing surgical wound
  – Assign code T81.89X-, Other complications of procedures, not elsewhere classified
  – If a postsurgical wound does not heal due to infection, assign code T81.4XX-, Infection following a procedure
  – Assign code T81.3-, Disruption of wound, not elsewhere classified, if the wound was closed at one time and is no longer closed
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Please be sure to read the FAQ section to find out what types of questions we can or cannot answer.
June 18, 2014

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Thank you for your interest and participation.

Nelly Leon-Chisen, RHIA
Program Chairperson
American Hospital Association
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