Editor's note: The following article is provided as a supplement to the October 1 CDI Journal.

The American Hospital Association’s Coding Clinic for ICD-9-CM is one of the most important items a CDI specialist can have in his or her toolbox. It contains official advice from the ICD-9-CM cooperating parties as to how coders and CDI specialists must interpret and code submitted clinical scenarios. For example, within its pages is information on whether a documented condition or procedure can be coded, which diagnosis must be sequenced as a principal diagnosis, and what effect these codes will have on the various DRG methodologies.

Because coding professionals and retrospective auditors use Coding Clinic, CDI specialists must be familiar with its guidance, especially in circumstances in which they must query a physician.

Anyone can submit a question to Coding Clinic regarding a particular circumstance and receive official advice as to how to handle it. If deemed of special interest, Coding Clinic publishes a synopsis of the clinical question and advice on how to code in the given situation. In the first of a quarterly series of articles available to ACDIS members, James S. Kennedy, MD, CCS, director of FTI Healthcare in Atlanta, looks at the highlights from the third quarter 2009 issue as they relate to CDI.

Complications

Dissection of iliac artery (Coding Clinic, p. 3) and postoperative hyperglycemia (Coding Clinic, p. 5) both provide important insights into complications of surgery, specifically whether an event during or after surgery should be reported as a complication.

In the entry on p. 3, the physician documented a dissection of the iliac artery during the course of an angioplasty and stent placement. The dissection was only within the lesion undergoing the angioplasty, after which a stent was deployed. The proceduralist’s last note indicated that the “patient tolerated the procedure well without any complications. Successful angioplasty and stenting of right external iliac.”

Coding Clinic advises not to assign a code for the dissection in this case because the physician did not document its clinical significance nor did he document that the dissection was a complication. Specific to angioplasty,
Coding Clinic emphasizes that “when the dissection extends further than anticipated, leading to an occlusion, or is responsible for additional procedures and/or other complications, it is clinically significant in such cases and it would be coded and reported.” In essence, CDI specialists and coders are directed that localized dissections are integral to angioplasty and should not be coded unless otherwise indicated.

Of course, a CDI specialist can always query the clinical significance of an arterial dissection during the course of an interventional procedure or any other unusual occurrence during an operative procedure. Coding Clinic, second quarter 2007, pp. 11–12, discusses query guidance in the setting of serosal tears of the gastrointestinal system requiring repair that occurred during an excision of a retroperitoneal mass and adrenalectomy—a technically difficult procedure, notes Kennedy. In this entry, Coding Clinic advises the CDI specialist/coder to query the physician for the clinical significance of the serosal tears and repair, deeming that if the physician states that they are not significant (e.g., integral to a difficult procedure), they are not to be coded. On the other hand, Coding Clinic states that if a physician documents that they are complications of surgery, a coder should report a complication code.

There is one caveat: The same Coding Clinic states that an accidental or inadvertent dural tear during spinal surgery should always be coded with 349.31, emphasizing the guidance provided in Coding Clinic, first quarter 2006, p. 15, which states that a dural tear is always clinically significant due to the potential for cerebrospinal fluid leakage.

The scenario of postoperative hyperglycemia on p. 5 emphasizes previous advice that a physician must explicitly document whether a postoperative condition is a complication before it can be reported as such, unless otherwise directed by ICD-9-CM. In fact, Kennedy states that it is important to query all conditions labeled as “postoperative” if the physician has not indicated its clinical significance, such as its integral nature to the procedure or its status as a complication. “This is because many physicians use the term ‘postoperative’ as a descriptor of conditions occurring during the postoperative period, not to unwittingly designate expected consequences as complications when required by ICD-9-CM,” he says.

Some of these postoperative conditions include:

- **Postoperative ileus.** ICD-9-CM requires that this be coded as a gastrointestinal complication (997.4) unless the physician explicitly states that it is not or that the ileus was usual, customary, or integral to the procedure, thus not qualifying as an additional diagnosis. Remember that ileus documented as an adverse effect of medications is not a surgical complication; thus, only a code for ileus and an E code for the medications would be reported, as described in Coding Clinic, January-February 1987, pp. 13–14.
Postoperative atelectasis. Coding Clinic, fourth quarter 1990, p. 25, states that postoperative atelectasis documented in a progress note is not coded or reported if it is only an incidental radiographic or physical finding, given that it is self-limited. If, on the other hand, it qualifies as an additional diagnosis (i.e., it requires additional diagnostic studies, treatment, or length of stay), a coder may report code 997.3 (postoperative respiratory condition).

Pneumothorax. Iatrogenic pneumothorax qualifies as a flag in the Agency for Healthcare Research and Quality patient safety indicator methodology; however, it commonly occurs after pulmonary and thoracic spinal surgery. Coding Clinic, third quarter 2003, p. 19, states that code 512.1 (iatrogenic pneumothorax) should not be reported for a pneumothorax after spinal surgery based on x-ray findings without physician concurrence.

Some facilities want that [complication code] because it’s a CC and results in additional revenue. CDI specialists need to apply their clinical knowledge and anticipate the clinical relevance in a particular circumstance like these when they’re reading operative notes,” Kennedy says. He notes that CMS in the 2010 IPPS final rule is considering implementing a risk-adjusted complications index as a hospital value-based purchasing core measure in future years.

If adopted, complications will likely affect a facility’s reputation or, potentially, its long-term reimbursement. “While capturing complications is a CC and pays you today, it can bite you later if CMS adopts the risk-adjusted complications index as a core measure affecting payment,” Kennedy says.

Herceptin® therapy (p. 3)

This entry is important because it addresses whether a patient receiving adjuvant cancer therapy is considered to have a history of cancer or to actually have cancer when he or she has no overt clinical indicators of such.

The patient in this scenario had a malignant breast neoplasm excised and treated three years ago, currently has no clinical, radiographic, or pathological evidence of a breast neoplasm, and is still receiving treatment with Herceptin, a monoclonal antibody that stimulates the body’s immune system to kill cancer cells. Coding Clinic states that this case should be coded with 174.9 (malignant neoplasm of female breast, unspecified), followed by a V code for the Herceptin maintenance.

Adjuvant therapy is additional cancer treatment, such as chemotherapy, hormonal therapies (e.g., tamoxifen), radiation therapy, or a combination thereof, and is given to lower the risk that the cancer will recur. In essence, Coding Clinic states that if a patient receives an adjuvant treatment (in this case, Herceptin), a coder should report a code for the actual presence of the malignancy, not a V code indicating a history of it.
CDI specialists should be mindful that most malignancies under the skin are CCs, whereas history of a malignancy is not. If a patient has a history of a malignancy, it would be appropriate to query as to the status of the patient’s malignancy to determine whether microscopic cells requiring adjuvant therapy or expectant management are present, or whether the malignancy is completely cured, requiring no further intervention, Kennedy says.

**Moderate protein malnutrition (p. 6)**

This entry states that the term “moderate protein malnutrition” should not be reported with 260 (kwashiorkor), a condition caused by a severe protein deficiency that is usually seen in undeveloped areas of the world. *Coding Clinic* advises to report code 263.0 (malnutrition of moderate degree) for “moderate protein malnutrition.”

The significance of this guidance is that code 263.0 is not a CC in MS-DRGs, whereas code 260 is an MCC. Unfortunately, code 263.9 (malnutrition not otherwise specified) is a CC, encouraging some physicians and hospitals to be less specific in their definition and documentation of a patient’s nutritional status.

Coding departments should audit for the frequency of 260, as *Coding Clinic* has stated that the condition is rare in the United States. Review records with code 260 to determine whether the code fits the physician’s documentation and the clinical circumstances.

“Additionally, physicians, dietitians, coders, and CDI specialists may wish to collaborate in determining what clinical indicators support the different levels of malnutrition and obesity,” Kennedy says. “Afterwards, non-leading, templated progress notes and queries clarifying ambiguous, incomplete, or conflicting determinations of these clinical indicators can be developed.”

**Uncertain diagnoses (p. 7)**

*Coding Clinic* states that physician documentation of “appears to be” qualifies as an uncertain diagnosis, but that the statement “evidence of” is not uncertain. Therefore, “evidence of” a diagnosis should be coded and reported as a definitive diagnosis in the outpatient setting, whereas the statement “appears to be” as applied to a diagnosis cannot be reported for outpatients.

So how does this advice apply to the CDI specialist’s inpatient realm? The *ICD-9-CM Official Guidelines for Coding and Reporting* allow for coding of uncertain principal and additional diagnoses only when they are documented at the time of discharge. On October 3, Nelly Leon-Chisen, editor of *Coding Clinic*, emphasized this requirement at the national AHIMA Coding Roundtable, notes Kennedy. Since a coder cannot report uncertain diagnoses documented prior to the time of discharge, if physicians indicate uncertainty in the response to a query, CDI specialists must remind them to document their uncertainty at the time of discharge.
Consequently, if a CDI specialist sees the term “evidence of” next to a diagnosis, it can be safely coded regardless of where it appears in the medical record. For example, if a physician says “evidence of pneumonia,” a coder may report it no matter where it is documented. “But if he says that a patient appears to have pneumonia, it is considered as an uncertain diagnosis, for which the ICD-9-CM Official Guidelines state that, for inpatients, it must be documented at the time of discharge if it’s to be coded, and for outpatients it cannot be coded at all,” Kennedy says.

**Glioblastoma (p. 8)**

*Coding Clinic* allows coders to report 348.5 (cerebral edema, an MCC) as an additional diagnosis when the provider has evaluated and documented the clinical significance of the vasogenic edema in the medical record. Often, vasogenic edema due to tumors or other cerebral insults is treated with high-dose dexamethasone, mannitol, or ventilator-induced hyperventilation.

“Some CDI specialists don’t know to look for that and thus miss a potential MCC,” Kennedy says. “Should patients receive high-dose dexamethasone or mannitol, it is not unreasonable to query the physician for the condition addressed by the use of these agents.”

**Malignant brain tumor (p. 8)**

This entry reminds CDI specialists that x-ray findings, such as cavernous sinus compression due to malignant brain tumor, cannot be coded unless their clinical significance is indicated in a progress note by a treating physician. CDI specialists may wish to query for the significance of CT, MRI, and other diagnostic findings—provided that their anticipated answer meets the definition of an additional diagnosis, Kennedy says.

**Acute MI (Hospital A) transferred to Hospital B (pp. 9–10)**

In this scenario, a patient sustains a myocardial infarction (MI) at one facility and is subsequently transferred to a second facility for a coronary artery bypass graft or percutaneous transluminal coronary angioplasty.

*Coding Clinic* states that the acute MI must be coded as a principal diagnosis at the second facility instead of coronary artery disease (even though the reason for the transfer was to address the patient’s coronary artery disease) because the acute MI is still being actively treated. Although some CDI specialists may wish for the acute MI to be the secondary diagnosis so as to serve as an MCC, *Coding Clinic* advises against that.

“Given that *Coding Clinic* is official advice used by outside regulators to challenge query and coding appropriateness, CDI specialists and coders alike must familiarize themselves with its logic in order to successfully defend their coded output,” Kennedy says. “This should remind CDI specialists that, if they deviate from this, they will be held accountable by the RACs.”
Indwelling urinary catheter and UTI (p. 10)
This entry reminds CDI specialists that they cannot assume what seems to be clinically obvious, which in this case is that a urinary tract infection (UTI) in the presence of an indwelling catheter is due to that catheter. “The provider must clearly document the causal relationship,” says Coding Clinic. This would also apply in patients with a UTI who self-catheterize or have a suprapubic catheter, Kennedy says.

“This is the role of the CDS—to clarify these scenarios prior to the patient being discharged and query for it every time we see it,” Kennedy says. “We are required by Coding Clinic to document the causal relationship.”

Kennedy offers the following sample query:

Dear Dr. Jones/Hospitalists,

The patient is admitted for pneumonia. It is also documented in the record that the patient has an indwelling Foley catheter and a UTI for which the patient is receiving levofloxacin. If possible, please describe the likely cause of the UTI in this circumstance. Thank you.

Acute delirium due to dementia (p. 11)
In this scenario, Coding Clinic requires clarification as to the type of dementia when a provider documents “delirium due to dementia.” If the answer is senile dementia with delirium, a coder may report 290.3 (senile delirium with dementia). If the cause is not known or documented, a coder must assign 294.8 (other persistent mental disorders due to conditions classified elsewhere) or 293.0 (delirium due to conditions classified elsewhere).

Bottom line, if a patient has dementia, a CDI specialist must always query physicians for the type. “I would also add that it’s important to query for the underlying cause,” Kennedy says. “Dementias can be due to many neurodegenerative disorders, such as Alzheimer’s disease, Lewy body dementia, or toxic encephalopathies (e.g., lead poisoning).”

Kennedy also suggests that CDI specialists should seek to distinguish between “multi-infarct dementia” and “dementia due to the late effect of stroke.” Multi-infarct dementia (codes 290.40–290.43, depending on any linked behavioral disturbance) sequenced as a principal diagnosis groups to a psychiatric Major Diagnostic Category (MDC). However, “dementia as a late effect of stroke,” which codes to 438.0 (cognitive defects as a late effect of stroke), followed by 294.11 (dementia in conditions classified elsewhere) groups to a neurological MDC if 438.0 is the principal diagnosis.

“Even though in most physicians’ eyes ‘multi-infarct dementia’ means ‘dementia due to a late effect of stroke,’ ICD-9-CM does not allow the coder to assume or code that. The physician must explicitly write ‘late effect of stroke’ in the setting of multiple infarcts if the ‘late effect of stroke’ codes are to be captured,” Kennedy says.
Near drowning with acute respiratory failure (p. 14)

This question asks whether drowning or acute respiratory failure is the principal diagnosis in the example of a young girl who nearly drowned. She had been diagnosed with first-time seizure six months ago, which may have precipitated the near drowning. Coding Clinic states that both conditions meet the definition of principal diagnosis and either may be reported first.

“If a CDS is not certain what should be the principal diagnosis, don’t ask yourself why they were admitted,” Kennedy says. “Ask why they couldn’t go home; the principal diagnosis can then be better identified. Not all drowning patients have to be admitted, but those in respiratory failure can’t go home.” Even so, if two or more conditions equally qualify as the principal diagnosis, either may be sequenced first, provided coding rules do not dictate otherwise.

Multilobar pneumonia (p. 16)

In this scenario, a physician documented “multilobar pneumonia.” Coding Clinic instructs the coder/CDI specialist to query for the specific type of pneumonia and to code based on the causal organism. It also emphasizes that the term “lobar pneumonia” is outdated, given that it codes only to 481, pneumococcal pneumonia, whereas other organisms may be involved.

“CDI specialists have the responsibility to query for the bacterial type of pneumonia, especially if the physician uses nonspecific language like ‘healthcare-associated’ or ‘nosocomial’ pneumonia,” Kennedy says. He offers the following sample query:

Dear Dr. Jones/Hospitalists,

The patient was admitted for pneumonia and is receiving the following antibiotics: ____________________________________. If possible, please indicate the likely organisms or circumstances responsible for this pneumonia for which these antibiotics were prescribed. Thank you.

Pediatrics (p. 17)

For patients insured by private insurers or Medicaid, especially those that reimburse inpatient admissions using DRG methodologies, obstetrics and neonatology provide documentation challenges usually not seen in the Medicare population. Although a full discussion is beyond the scope of this article, Kennedy says CDI specialists reviewing these cases should be familiar with complicating diagnoses with vaginal delivery and major or significant problems in premature and normal newborns.

For newborns, the ICD-9-CM Official Guidelines for Coding and Reporting states that all clinically significant conditions noted on routine newborn examination should be coded. A condition is clinically significant if it requires any of the following:

- Clinical evaluation
- Therapeutic treatment
The guidelines emphasize that the perinatal guidelines listed above are the same as the general coding guidelines for “additional diagnoses,” except for the final point regarding implications for future healthcare needs. Codes should be assigned for conditions in newborns that have been specified by the provider as having implications for future healthcare needs. Although codes from the perinatal chapter should not be assigned unless the provider has established a definitive diagnosis, the guidelines for uncertain diagnoses documented at the time of an inpatient discharge still apply.

In this question, the provider documented peripheral pulmonary stenosis (PPS) murmur (note this is not pulmonary valve stenosis) as a discharge impression/diagnosis in a vaginally delivered full-term infant. Although the physician provided no documentation of therapeutic treatment or other diagnostic exams, the provider documented, “Will discharge home and follow up tomorrow.”

In this example, given that PPS was documented in the discharge summary and was described as requiring follow-up, Coding Clinic allows a coder to report 747.3 (anomalies of the pulmonary artery) as an additional diagnosis. Code 747.3 serves a “significant medical problem” in normal newborns, changing MS-DRG 79, normal newborn (relative weight [RW] 0.1617), to MS-DRG 794, neonate with other significant problems (RW 1.1941).

Kennedy says this advice is significant because Coding Clinic emphasizes that 747.3 was documented as a discharge diagnosis, implicating the need for future healthcare.

Once again, this Coding Clinic entry stresses the importance of a completed discharge summary on the final coded output. “Physicians and coders have mutual accountability for the availability and quality of the discharge summary, given that this document is probably the most important contributor to ICD-9-CM coded data quality,” Kennedy says.

CDI specialists should encourage their medical staff members to promptly perform discharge summaries upon the patient’s discharge so they are available to coding staff members. “Emphasize the physician’s need to reiterate all diagnoses addressed during the hospital stay with high specificity, to repeat all pertinent uncertain diagnoses—given these can be coded only if documented at the time of discharge—and to clarify all pending present-on-admission issues,” Kennedy says.

Coding Clinic addressed other neonatal issues in this issue as well. These include the following:
Coding hypermagnesemia in newborns, generally defined as a serum concentration over 2.5 mEq/liter (p. 21). *Coding Clinic* states that the coder/CDI specialist should query the provider to determine whether the baby’s hypermagnesemia resulted from the mother’s treatment with magnesium sulfate (e.g., for preeclampsia), or whether the condition is due to a metabolic problem in the infant. Hypermagnesemia is a major problem in full-term neonates, which, if present, results in MS-DRG 793, full-term neonate with major problems (RW 3.3738), Kennedy says.

- A murmur linked to a likely underlying cause; for example, patent ductus arteriosis or patent foramen ovale (p. 17). In this case, a coder should only report the underlying cause. Kennedy says the term “likely” indicates uncertainty according to the *Official Guidelines*, thus it must be documented at the time of discharge.

- A neonate in respiratory distress (pp. 20–21). CDI specialists or coders cannot assume that a neonate in respiratory distress has respiratory distress syndrome or transient tachypnea of newborn unless defined and documented by the physician.

**Hypoxia and COPD (p. 20)**

*Coding Clinic* states that hypoxia is not inherent in chronic obstructive pulmonary disease (COPD) and thus may be reported as an additional diagnosis (799.02), when appropriate.

Kennedy says CDI specialists should clarify whether the hypoxia was transient or indicates the presence of acute, chronic, or acute-on-chronic hypoxemic respiratory failure. He notes that the February 2006 *Coding Clinic* states that hypoxia is integral to acute respiratory failure, thus code 799.02 should not be reported if respiratory failure is documented. ■