Prepare for ICD-10 with anatomy/physiology education

Do you know what the Billroth II procedure is? If you don’t, you may have a hard time coding it after CMS/HHS implements the ICD-10-PCS system October 1, 2013.

In the ICD-10 coding system, neither the procedure nor the diagnosis indexes will include eponyms (terms derived from the name of a person) such as the Billroth II procedure (43.7). Instead, the names will have more specific descriptions of what the procedure entails, says Nelly Leon-Chisen, RHIA, director of coding and classification at the American Hospital Association in Chicago.

In this example, the coder would need to know that a Billroth II procedure is a partial gastrectomy with anastomosis to jejunum.

The transition to the ICD-10-CM and ICD-10-PCS system, which is far more specific and includes thousands more codes than the ICD-9-CM system, will require an increased understanding of anatomy and physiology, medical terminology, and disease process, says Gloryanne Bryant, RHIA, CCS, CCDS, regional managing director of HIM at Kaiser Permanente in Oakland, CA.

“ICD-10 is more specific, not only in diagnosis but in procedure coding as well,” Bryant says. “Coders need to understand the medical details [of diagnoses and procedures] to better capture the specific code.”

Prepare for greater specificity, more codes

A lack of eponyms is not the only change coders will notice in the ICD-10 system. Capturing an ICD-10 code may require knowledge of very specific details about a diagnosis or procedure that wasn’t necessary under the ICD-9 system.

For example, a coder reporting an angioplasty under ICD-9 must know whether the physician repaired a vessel in the heart or elsewhere to choose the right code. However, in ICD-10, the coder will need to know the specific vessel the physician worked on. The ICD-10-PCS includes more than 1,000 codes for angioplasty, all specified by individual vessels.

“ICD-10 is more specific, not only in diagnosis but in procedure coding as well.”

—Gloryanne Bryant, RHIA, CCS, CCDS

You would have to know the different names for the different vessels,” Leon-Chisen says.

Much of the information coders will need should be in the record documentation. However, a deeper knowledge of anatomy/physiology and medical terminology will make the ICD-10 transition far smoother, Bryant says.
ICD-10  
< continued from p. 1

During a visit to British Columbia, Canada, in October 2008, Bryant interviewed a group of hospital coders who have been using the ICD-10 system for several years.

Although the coders all agreed that ICD-10 has some challenging aspects to learn as far as understanding procedures and anatomy/physiology, they also agreed that they would “never go back to ICD-9,” Bryant says.

ICD-10’s detailed coding system will help staff members more easily gather data on their facility as well as its practices and patient population. Facilities use coded data for several purposes, such as outcome statistics, which will also be greatly enhanced by the ICD-10 coding system, Bryant says.

For example, if a coding manager asked a coder to look at the surgical outcomes for vessel repairs in legs, under the ICD-9 system, that coder would need to sift through the documentation for each record, determining which procedures the physician performed in the leg. In the ICD-10 system, the coder will easily be able to retrieve these data, since the code specifies where the physician made the repair.

Educate your coders

As part of your preparation work for ICD-10, consider ways to offer coders more education on anatomy/physiology and medical terminology. “Now would be a good time to put into your budget money for this type of education,” Bryant says.

Seasoned coders who are used to the current ICD-9 code descriptions will especially need refresher education, Leon-Chisen says. However, “new coders shouldn’t have a problem,” she adds. “You normally have to take anatomy/physiology for a coding course, so it’s all fresh.”

If you’re not sure about your coders’ needs, conduct an internal survey to gauge their thoughts. Ask them how comfortable they are with anatomy/physiology and the transition to ICD-10, as well as what kind of education they’d prefer. Some might prefer to take a class, whereas others might prefer online education. (See the sample coder survey on p. 3.)

“Ask the coders and get their input,” Leon-Chisen says. “Look for tools that would be helpful.”

ICD-10 Blog

For more information on ICD-10, visit our blog, ICD-10 Watch, at http://blogs.hcpro.com/icd-10. You can also visit CMS’ Web site (www.cms.hhs.gov/ICD10) for government updates and resources.
**ICD-10 Hospital Coder Survey**

**Determine your coders’ need for anatomy/physiology education**

1. Have you had ICD-10 coding training?
   - a. Yes
   - b. No

2. If yes, how many hours? ________________________
   ____________________________________________
   ____________________________________________

3. Do you need additional anatomy, physiology, and disease process education to better code with ICD-10?
   - a. Yes
   - b. No
   - c. I don’t know

4. The following is a list of the 24 categories used with MS-DRGs. Please select the top four categories for which you feel you need additional education for diagnosis coding.
   - a. Nervous
   - b. Eye
   - c. Ear/nose/throat
   - d. Circulatory
   - e. Respiratory
   - f. Digestive
   - g. Hepatobil/pancreas
   - h. Musculoskeletal
   - i. Skin, subcutaneous tissue
   - j. Endocrine, nutritional, metabolic
   - k. Kidney/urinary
   - l. Male reproductive
   - m. Pregnancy/childbirth
   - n. Newborns
   - o. Blood and blood-forming organs and immunological disorders
   - p. Myeloproliferative (poorly differentiated neoplasms)
   - q. Infectious and parasitic
   - r. Mental diseases and disorders
   - s. Alcohol/drug use or induced mental disorders
   - t. Injury, poison, and toxic effect of drugs
   - u. Burns
   - v. Factors influencing health status
   - w. Multiple significant trauma
   - x. Human immunodeficiency virus infection

5. How do you prefer your educational programs to be presented?
   - a. Video
   - b. Audio
   - c. In-person seminar/classroom
   - d. Online/Web-based
   - e. A combination

6. Please provide any comments or suggestions: _______
   ____________________________________________
   ____________________________________________
   ____________________________________________

**Source**
Gloryanne Bryant, RHIA, CCS, CCDS, regional managing director of HIM, Kaiser Permanente, Oakland, CA.

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**Share your bright idea and win a book!**
If you’ve developed a unique way to save money at your inpatient facility, created a new policy that has saved you time, or started a program that improved patient care, we’d love to hear about it. Send us your brilliant ideas, and your facility may be featured in BCCS. The person with the best idea will receive a copy of *Coder Productivity: Tapping your Team’s Talents to Improve Quality and Reduce Accounts Receivable.*

Contact Executive Editor Ilene MacDonald by telephone at 781/639-1388 or e-mail imacdonald@hcpro.com.
Determine effect of MS-DRG changes in 2010 IPPS final rule

The 2010 IPPS final rule included several changes related to MS-DRGs, complications and comorbidities (CC), and major CCs (MCC) that you need to know about.

During the September 29 HCPro audio conference, “2010 IPPS MS-DRG Update: Analyze the Rule and Understand the Impact,” Robert S. Gold, MD, CEO of DCBA, Inc., in Atlanta, and Gloryanne Bryant, RHIA, CCS, CCDS, regional managing director of HIM at Kaiser Permanente in Oakland, CA, discussed these changes. Gold and Bryant also offered HIM directors and coding managers tips for analyzing their MS-DRG volumes, improving documentation, and evaluating coding practices.

Payment increases and decreases

The IPPS rule included several payment increases and decreases, depending on whether there is a CC or MCC present. These increases and decreases include the following MS-DRGs:

- **444**: Disorders of the biliary tract with MCC—decrease of 1.64%
- **445**: Disorders of the biliary tract with CC—decrease of 1.79%
- **446**: Disorders of the biliary tract without MCC/CC—increase of 1.92%
- **760**: Menstrual and other female reproductive system disorders with CC or MCC—decrease of 0.07%
- **761**: Menstrual and other female reproductive system disorders without CC or MCC—decrease of 1.33%
- **846**: Chemotherapy without acute leukemia as secondary diagnosis with MCC—increase of 2.46%
- **847**: Chemotherapy without acute leukemia as secondary diagnosis with CC—increase of 0.96%
- **848**: Chemotherapy without acute leukemia as secondary diagnosis without an MCC or CC—increase of 3.19%

Look at your highest-volume cases and determine how these MS-DRG payment changes will affect reimbursement at your facility, Gold said.

For example, if your facility has a high volume of MS-DRG 848, this change will affect your reimbursement for 2010.

Relative weight increases and decreases

The MS-DRG with the highest relative weight increase was MS-DRG 1, heart transplant or implant of heart assist system with MCC, with an increase of 1.1847.

The MS-DRG with the highest relative weight decrease was MS-DRG 2, heart transplant or implant of heart assist device without MCC, with a decrease of 1.0618.

Five of the top 21 relative weight increases involve debridement procedures:

- **622**: Skin grafts and wound debridement for endocrine, nutrition, and metabolic disorder with MCC—increase of 1.0557
- **463**: Wound debridement and skin graft except hand, for musculoconnective tissue disorder with MCC—increase of 0.6078
- **573**: Skin graft and/or debridement for skin ulcer or cellulitis with MCC—increase of 0.3354
- **465**: Wound debridement and skin graft except hand, for musculoconnective tissue disorder without CC or MCC—increase of 0.2930
- **464**: Wound debridement and skin graft except hand, for musculoconnective tissue disorder with CC—increase of 0.2217

So why are five of the top 21 relative weight increases wound debridement procedures? Gold said no one is reporting debridement as frequently due to concerns regarding Recovery Audit Contractor (RAC) audits.
“People are afraid of assigning the code because of [the risk of] inappropriate assignment,” Gold said. “It is seen as an overcoded procedure.”

Gold suggested evaluating cases at your facility with code 86.22, excisional debridement of wound, infection, or burn.

Focus on the physician’s documentation—the fact that it says “excisional debridement” in the documentation isn’t enough, Gold said.

“We have to understand what the goal was for assigning the code for debridement of the skin. The intent should be met in the physician’s documentation,” he said. “The fact that the physician says excisional debridement in the report doesn’t prove excisional debridement—that’s where you get into trouble, and that’s where you can be accused of overcoding.”

**Coding concepts and clinical knowledge**

Clinical knowledge is an essential element for capturing severity and MS-DRG assignment, Bryant said. “When we’re talking about DRG changes and coding changes, it’s important to enhance clinical knowledge,” she said.

Additionally, refresh your knowledge of the following core concepts for coding accuracy:

➤ **Case-mix index.** Track this monthly and look for changes. What is your highest-volume DRG, primary diagnosis, and secondary diagnosis?

➤ **Accurate and complete coding.** Know the Uniform Hospital Discharge Data Set definition of principal diagnosis: “that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.”

➤ **Physician documentation.** This is key to accurate code assignment. Have your clinical documentation improvement specialist determine where improvements are needed.

➤ **Coding audits.** Perform audits regularly to evaluate accuracy and potential over- or undercoding.

“These are great actions to take to ensure accuracy in documentation, case-mix index, and certainly your MS-DRGs,” Bryant said.

*Editor’s note: For more information or to purchase a recording of this audio conference, visit www.hcmarketplace.com or call 877/727-1728.*

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**Update your ICD-9 knowledge**

**New, deleted, and revised diagnosis codes**

*Editor’s note: The following is an excerpt from the HCPro book Understanding and Applying the 2010 ICD-9-CM Codes, by Robert S. Gold, MD, and Shannon E. McCall, RHIA, CCS, CCS-P, CPC-I, CCDS*

The 2010 update brings more specificity to the coding world, with no significant modifications to the MS-DRG groupings. Most changes are actually expansions or clarifications of issues raised in the 2009 code modifications. The codes are effective October 1, 2009.

Some of the major code groupings undergoing change this year include more specificity to the neuroendocrine tumors (we had a breakdown of carcinoids last year), specificity of acute and chronic venous occlusions and the parts of the body in which these may be found, some introduction to puerperal sepsis, breakdown of hypoxic encephalopathy by severity, and poisonings by specific medications.

There are also 32 new V codes and 175 new E codes, with some concentration on psychosocial family statuses, a few new personal history codes, and expansion on the screening laboratory services. The E codes saw the greatest number of additions with the new Activity codes.

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ICD-9 knowledge < continued from p. 5

(E000–E030). This is the largest expansion of E codes in many years. E codes routinely have been reported to establish how and/or where accidents, injuries, and poisonings occur. With the Activity codes, the E codes will now state what the patient was doing when the injury occurred. At the request of the U.S. military, many new E codes cover injuries sustained in war.

Within the area of procedures, we introduce several devices presented for various organs (heart, liver, lung, colon) and codes for embolization of bioactive coils for occlusion of vessels and colonic stent insertion.

There are 43 revised ICD-9-CM diagnosis codes but no revised procedure code definitions for 2010.

The following text and explanations are based on the final publication of 2010 codes published online. Visit the Centers for Disease Control and Prevention (CDC) Web site at www.cdc.gov/nchs/icc/icd/icd9cm.htm for further information.

Code development is an interesting process. Visit the following AHIMA and CMS sites for discussion of many of the new codes, as well as those that were not implemented:

➤ http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_044029.pdf#page%3D2
➤ www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/03_meetings.asp

For the first time in years, there are no new codes for infectious diseases. The CDC prepared some new codes for H1N1 flu, also known as the swine flu. They appear later in the 488 series. Although 008.65 is said to have been “redefined” as enteritis due to Calicivirus, it has already been that for years. The intent most likely was to redefine 008.63 as Norwalk virus or Norovirus; this is the new portion.

There was a large series of codes for carcinoid tumors last year, both benign and malignant, some dependent on the portion of the intestine or other organ or origin of these tumors. They are derived from the neural crest layer of the early embryo and are referred to as neuroendocrine tumors. Carcinoids are not the only neuroendocrine tumor, however, and providing code sets for other relatively common tumors derived from the same cellular origin from the embryo was advisable. Toward that goal, there is now a series of codes for Merkel cell carcinoma and additional codes for metastatic sites for neuroendocrine tumors:

➤ 209.31, Merkel cell carcinoma of the face
➤ 209.32, Merkel cell carcinoma of the scalp and neck
➤ 209.33, Merkel cell carcinoma of the upper limb
➤ 209.34, Merkel cell carcinoma of the lower limb
➤ 209.35, Merkel cell carcinoma of the trunk
➤ 209.36, Merkel cell carcinoma of other sites
➤ 209.70, Secondary neuroendocrine tumor, unspecified site
➤ 209.71, Secondary neuroendocrine tumor of distant lymph nodes
➤ 209.72, Secondary neuroendocrine tumor of liver
➤ 209.73, Secondary neuroendocrine tumor of bone
➤ 209.74, Secondary neuroendocrine tumor of peritoneum
➤ 209.75, Secondary Merkel cell carcinoma
➤ 209.79, Secondary neuroendocrine tumor of other sites

Merkel cell carcinoma, a rare form of skin cancer usually occurring in sun-exposed areas of the skin, is often referred to as “MCC.” Don’t confuse this acronym with a major complication and comorbidity. However, providers may see synonyms used properly, such as apudoma of the skin (to distinguish them from neural crest tumors of other organs that have similar chemical characteristics), trabecular cell cancer, or small cell neuroepithelial tumor of the skin.

The disease previously was bundled under ICD-9-CM code set 173, Other malignant neoplasms of the skin. Recognizing the unique characteristics and potential for rapid metastasis of this tumor, physicians and researchers from Seattle requested special code sets to identify its
specificity. Providers are familiar with other much more common malignancies of the skin: squamous cell carcinoma, basal cell carcinoma, and malignant melanoma (172 series). These tumors resemble cysts at first, then they grow rapidly and spread. They are staged by size and by metastatic locations.

Metastatic sites include other areas of the skin, lymph nodes, liver, lung, bone, and brain. Other concepts that apply to these tumors include predominance of areas of the skin with long sun exposure. This often occurs in individuals aged 65 and older. It is often associated with immunosuppression, such as in patients with transplanted organs or HIV, and with the finding of a particular polyoma virus (Merkel cell virus, or MCV) in 80% of the tumors.

Merkel cells are presumed to be tactile sensors in the skin—cells of the nervous system that detect the sensation of touch. Diagnosis usually is based on biopsy of a newfound lesion of the skin presumed to be a squamous or basal cell lesion. The rapidity of its growth and spread makes excision as quickly as possible important.

These codes are categorized according to location of the primary tumor, similar to other skin cancers in the 172 and 173 categories. Location codes for metastatic sites for all neuroendocrine tumors, carcinoids, Merkel cell tumors, and others that have had no special code assigned are now available.

A problem exists, however. Specifically, 209.75 should not be classified as secondary Merkel cell carcinoma. Carcinoid is a neuroendocrine tumor that exists more frequently than Merkel cell, and it doesn’t have its own code in this group.

Also, all 209 series codes are specified by location, so these codes stand out as not belonging there at all:

➤ V10.90, Personal history of unspecified malignant neoplasm
➤ V10.91, Personal history of malignant neuroendocrine tumor

These are added to complete the historical cycle of patient care for neuroendocrine tumors.

Open Door Forum addresses nursing charges, principal diagnosis

CMS hosted a Hospital & Hospital Quality Open Door Forum (HODF) conference call October 8, in which it discussed the following items of interest.

Nursing services

A CMS representative provided additional information in answer to a question from the previous HODF, held August 26. The question was whether nursing services can be included in charges for ancillary services or whether they are included in the hospital’s routine charges for room and board.

The Provider Reimbursement Manual, Section 2202.6, states:

Routine services are composed of two board components; (1) general routine services, and (2) special care units (SCUs), including coronary care units (CCUs) and intensive care units (ICUs). Included in routine services are the regular room, dietary and nursing services, minor medical and surgical supplies, medical social services, psychiatric social services, and the use of certain equipment and facilities for which a separate charge is not customarily made.

Therefore, the charges for nursing services would be included in the charges for routine services.

During the question-and-answer period, a caller asked whether all routine services—even services not provided to all patients in the nursing unit—have to be encapsulated in the room rate, or whether hospitals can use other routine revenue codes (that map to the nursing

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cost centers) to recognize atypical nursing services that patients receive at different rates. The CMS representative said that, as a general principle, hospitals should report charges on a claim the same way they report costs on their cost report.

Codes unacceptable as principal diagnosis

During the question-and-answer period, a caller asked about an edit in the Medicare Code Editor (MCE) that CMS addressed in the recent IPPS final rule (see 74 Federal Register 43790). Here, CMS states that it “had not intended that the series of codes at subcategory 209 were only acceptable as secondary diagnoses” and finalizes its proposal to remove these edits from the MCE. CMS had also instructed contractors via an internal joint signature memorandum that they should override this edit and process these claims.

However, the caller reported that her contractor was still applying these edits. A CMS representative indicated that she would follow up with the caller after the HODF.

Section 1011 update

A CMS representative encouraged providers to monitor the Section 1011 Web site to determine whether funds are still available in their states for the next scheduled payment. To learn more, go to www.trailblazerhealth.com/Section_1011.

Editor’s note: The next HODF conference call is scheduled for Thursday, November 19.

Coding Clinic update

Complications of surgery, uncertain diagnoses, and more highlight important updates for coders

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

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 synopses of the clinical question and advice on how to code in the given situation.

Dissection of iliac artery (p. 3); postoperative hyperglycemia (p. 5)

The entries on pp. 3 and 5 are both 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, coders are directed that localized dissections are integral to angioplasty and should not be coded unless otherwise indicated.

Of course, a coder can always query as to 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 James Kennedy, MD, CCS, director of FTI Healthcare in Brentwood, TN. In this entry, Coding Clinic advises the coder to query the physician for the clinical significance of the serosal tear 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 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 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 submitted, 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 a 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; how-

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Questions? Comments? Ideas?

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ever, it commonly occurs after pulmonary and thoraic 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 [complication and comorbidity (CC)] and results in additional revenue. [Coders] 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 complication index as a core measure,” Kennedy says.

Herceptin® therapy for breast cancer (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.

Coders 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. 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 a major CC. Unfortunately, code 263.9, malnutrition not otherwise specified, is a CC, encouraging some physicians and hospital to be less specific in their definition and documentation of a patient’s nutritional status.

Coding departments should audit for the frequency of code 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 clinical documentation improvement 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.”

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significant atherosclerosis of the major vessels in the abdomen or the leg, a seemingly inevitable amputation may be delayed or even averted by increasing blood flow to the foot through a bypass procedure (aortofemoral, aortoiliac, axillofemoral, femoropopliteal bypass). This increases inflow to the lower leg, foot, and toes, bypassing atherosclerosis. You cannot bypass the diseased vessels of diabetes—they are far too small.

Amputation, debridement, or other local procedures can be done for the ravages of diabetes, sequencing the 250.xx code first per ICD-9-CM coding guidelines. However, when a physician performs a bypass, sequence the code for atherosclerosis first.

Reduction of volvulus

Coding Clinic, first quarter 2003, addresses the overuse of ICD-9-CM code 46.85, dilation of intestine. Coders often assign this code when the physician inserts a tube into the intestine to let the air out. For example, in sigmoid volvulus, the sigmoid colon is twisted around, developing a closed-loop obstruction and trapping gas-forming bacteria.

What do those bacteria do in the volvulized sigmoid? They produce gas, and that gas massively distends the loop of the sigmoid colon. Sometimes physicians treat this condition in the x-ray department by gently injecting barium solution to untwist (physicians say “detorse”) the bowel. If the physician is successful, he or she will insert a large red rubber tube to decompress the bowel and let out all the retained air and other particulate matter from the intestine.

Look up the codes for this procedure. If you look in the index for intubation of intestine, you’ll find 96.08—that’s a nasointestinal tube insertion, like a Miller-Abbott tube for decompression of the upper gastrointestinal tract. Now look for intubation of colon, and you’ll see it’s the same code as intubation of intestine.

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But right next to it is insertion of rectal tube. Now you have it: 96.09.

The 46.8x series is specifically designed for open surgical intervention, not the performance of a barium enema and insertion of a red tube. If the physician uses a balloon to dilate a stricture, then 96.09 is appropriate. The index will not lead you to the correct code. This is not 46.85.

**Bronchoscopic biopsy vs. transbronchial lung biopsy**

Bronchoscopy is a frequently performed procedure. Physicians perform this procedure for diagnostic or therapeutic reasons, or sometimes both. Usually, physicians do bronchoscopy diagnostically to determine the presence or absence of a lung malignancy or some irritating or infectious process.

As part of almost every procedure, the physician will try to visualize the trachea, the right and left lobar or mainstem bronchi, the segmental bronchi (the tubes that go to the various segments of the lungs), and as far down he or she can see. He or she looks at the mucosal lining of the tubes and at the splits—the forks in the road—where a larger bronchus splits into smaller ones. The physician wants to see sharp divisions. If the physician determines that there’s a mass ahead of the divisions or a mass within the bronchus, he or she will do washings, brushings, and a biopsy of what he or she sees. If the physician performs a biopsy of what he or she sees, then it’s a bronchoscopy with biopsy—ICD-9-CM code 33.24.

Coders must specifically use code 33.27 when the physician documents that he or she passed biopsy forceps through the wall of the bronchus, often under fluoroscopic control, into a peripheral lung mass that he or she cannot see. The physician may refer to the mass as a coin lesion or a peripheral lung lesion.

If the physician can see it and biopsy it, assign code 33.24. If he or she cannot see it and passes the forceps through the wall into the lung tissue, assign code 33.27. The former is a non–operating room procedure; the latter is an operating room procedure. Make sure you choose the right code to avoid overcoding. If you are unsure which is the right code assignment, check with the physician.

*Editor’s note: Dr. Gold is CEO of DCBA, Inc., a consulting firm in Atlanta that provides physician-to-physician programs in clinical documentation improvement. The goals are data accuracy, profile management, and compliance for physicians and hospitals in the inpatient and outpatient arenas. Reach him by phone at 770/216-9691 or by e-mail at DCBAInc@cs.com.*
We have always been taught that coders are not allowed to code from nurses’ notes. Can anyone tell me where I can find documentation of this coding rule?

According to Coding Guidelines, effective October 1, 2008:

The term encounter is used for all settings, including hospital admissions. In the context of these guidelines, the term provider is used throughout the guidelines to mean physician or any qualified health care practitioner who is legally accountable for establishing the patient’s diagnosis. Only this set of guidelines, approved by the Cooperating Parties, is official.

In p. 8 of the March 2008 BCCS, Lori S. McGuire, CCS, EMT, founder of Simply Coding in Nevada, OH, states: “There are several areas of the record that coders should not use when assigning a code. For example, coders should never code from a nurse’s notes. However, notes that a nurse provides can assist coders who are looking for important clues that might lead to a particular diagnosis. If this information is missing from the physician’s documentation, coders can query the physician regarding a condition that a nurse may have intimated.”

Sandra Sillman, RHIT, PAHM, DRG coordinator for medical record services at Henry Ford Health System in Detroit, answered the previous question.

How should we code a CT triple rule-out study? A provider performs this scan (i.e., a chest CT angiogram [CTA] and a coronary CTA) to rule out coronary artery disease, aortic dissection, and pulmonary embolism.

We know that CPT code 71275 (computed tomographic angiography, chest with contrast material[s], including noncontrast images, if performed, and image postprocessing) is a component of the CTA coronary category III codes 0146T–0149T. Can we report codes for both studies and append a modifier to code 71275?

The phrase “rule-out” does not affect procedure code assignment. Report the procedures as the physician actually performed them. ICD-9-CM Official Guidelines for Coding and Reporting for outpatients states that coders should never code a rule-out diagnosis. Instead, they should code only what they know for sure based on physician documentation. Therefore, only report the signs and symptoms that the physician documents in his or her notes as the reason for the tests.

The CPT Manual does not identify any exclusion that would prevent you from reporting code 71275 and code 0146T. As long as you have the supporting documentation, report both codes. Append modifier -59 (distinct procedural service) to the second code.

For more information, refer to the AMA’s CPT Assistant, January 2007, p. 31, and Clinical Examples in Radiology, Spring 2005, p. 7, published by the AMA and the American College of Radiology.

I work for an allergy, ear, nose, and throat clinic and am questioning a recent encounter that I

> continued on p. 2
reported and that was subsequently denied. I reported the following CPT codes for a patient’s hospital stay:

➤ 30520 (septoplasty or submucous resection, with or without cartilage scoring, contouring, or replacement with graft)
➤ 30140 (pterygomaxillary fossa surgery, any approach)
➤ 42831 (adenoidectomy, primary; age 12 or older)

The payer paid this claim. The patient then returned to the office almost two weeks later, and the physician performed an endoscopy procedure bilaterally. I reported CPT code 31237 (nasal/sinus endoscopy, surgical; with biopsy, polypectomy, or debridement) with modifier -50. The payer denied this procedure and said it was included in the global surgery period for code 30520. Is there anything I can do to remedy this and receive payment for the endoscopy procedure?

CPT codes 30520, 30140, and 42831 indicate that the physician’s work on this patient’s nasal and sinus cavities was extensive. The payer may have denied the claim because it wondered why the physician didn’t take the tissue for the biopsy during the resection rather than perform a separate surgical nasal/sinus endoscopy two weeks later.

I recommend that the physician write a letter to the payer explaining why he or she did not perform the biopsy at the same time as the other procedures. Essentially, he or she needs to justify performing the additional procedure as well as the timing of that additional procedure.

A patient presents with breast pain and is diagnosed with a diabetic abscess of the breast. A surgeon performs an incision and drainage of the abscess and states that the abscess is due to diabetes.

Should I report ICD-9 code 250.80 (diabetes with other specified manifestations) or code 250.90 (diabetes with unspecified complication)? Also, I need to report a manifestation code, but when I report code 611.0 (inflammatory disease of breast: abscess of breast), my coding software rejects it.

You cannot report ICD-9 code 250.90 (diabetes with unspecified complication) because the surgeon specified the abscess as the manifestation. Instead, report ICD-9 code 250.8x. I agree that ICD-9 code 611.0 (inflammatory disease of breast; abscess of breast) is the most accurate manifestation code. It is possible that your coding software rejected it because of a lack of a commonly accepted physiological connection between the diabetes and the breast abscess.

My first suggestion is to gather the research or evidence of this physiological connection. For example, consider looking at evidence-based medicine guidelines in The New England Journal of Medicine or other published research. Should your claim be denied, submit this evidence with your appeal. This will provide justification to override the software rejection of the codes.

If you cannot find evidence, report diabetes code 250.0x (diabetes mellitus without mention of complication) along with code 611.0, and eliminate the connection between the diabetes mellitus and the breast abscess.

Shelley C. Safian, MAOM/HSM, CCS-P, CPC-H, CHA, of Safian Communications Services in Orlando, FL, answered the previous three questions, which were originally published in JustCoding.com. Safian is a senior assistant professor who teaches medical billing and insurance coding at Herzing University Online in Milwaukee. E-mail her at ssafian@embarqmail.com.