Editor’s note: The following article is provided as a supplement to the January CDI Journal.

In the second of a quarterly series of articles available to ACDIS members, James S. Kennedy, MD, CCS, managing director at FTI Healthcare in Atlanta, takes a look at the highlights from the fourth quarter 2009 issue of AHA Coding Clinic for ICD-9-CM as they relate to CDI. This quarter features an added emphasis on documentation at the time of discharge, CDI opportunities in diabetic patients, and changes to coding and reporting of obstetrics patients.

Documentation of uncertain diagnoses at the time of discharge (p. 172)

Many CDI specialists are under the mistaken impression that uncertain diagnoses (e.g., those qualified as possible, probably, likely, suspected, still to be ruled out, or other similar terms) can be coded if they are documented anywhere in the record.

That is not true, given that the fourth quarter 2009 Coding Clinic and the ICD-9-CM Official Guidelines for Coding and Reporting (since at least 2000) both emphasize that diagnoses must be “documented at the time of discharge” in order for a coder to report them.

This Coding Clinic emphasizes that the present-on-admission (POA) indicator is affected as well. If the final diagnosis (note the word “final”) contains a possible, probable, suspected, or rule-out diagnosis, and this diagnosis was based on signs, symptoms, or clinical findings suspected at the time of inpatient admission, a coder may assign a POA indicator of “Y.” On the other hand, if the final diagnosis (again, note the word “final”) contains a possible, probable, suspected, or rule-out diagnosis, and this diagnosis was based on signs, symptoms, or clinical findings that were not POA, a coder must assign “N.”

Although this information is not new, it is now bolded in the ICD-9-CM Official Guidelines for Coding and Reporting, lending it further emphasis.

The statement “at the time of discharge” does not imply that the diagnoses must be documented in the discharge summary in order for them to be coded, Kennedy says. Discharge notes, discharge orders, or similar documents are sufficient. “The bottom line is, a physician can document an
uncertain diagnosis 500 times throughout the progress notes, but if he or she does not document it at the time of discharge, the coder just simply is not allowed to code it,” he says.

What’s a CDI specialist to do when a physician answers a concurrent query with an uncertain diagnosis? Remind physicians that if they are treating a condition because it is suspected, they should document the suspected condition throughout the hospital stay and especially at the time of discharge in order for it to be coded, says Laura Doty, RHIT, a director at FTI Healthcare.

“When the physician continues treatment for an uncertain condition throughout the course, he needs to continue to use that language all the way through to the final progress note, discharge summary, and/or discharge order,” Doty says. “This step allows the coder to know that the suspected condition has not been ruled out.”

**Neuroendocrine tumor with MENS (p. 150)**

This entry clarifies that multiple endocrine neoplasia syndrome (MENS) should not be reported when the documentation or the response to a physician query does not support the condition.

The example given is of a patient admitted for resection of a large mesenteric metastatic carcinoid tumor who also had a history of a resection of a previous small bowel carcinoid tumor. This advice became necessary because the 2009 series of codes for neuroendocrine tumors (209) contains a “code first” instruction for any associated MENS.

Although rare, CDI specialists may wish to query for MENS for patients with carcinoid tumors. Not only does this help with data integrity, but MENS as a principal diagnosis changes the DRG from a digestive malignancy DRG 376 (0.88 relative weight) to an endocrine DRG 644, which carries a higher relative weight (1.04).

Kennedy reminds CDI specialists that patients with carcinoid tumors may have the carcinoid syndrome (code 259.2). Symptoms include flushing (pale, purplish, or red), diarrhea (watery and explosive), tachycardia or hypotension, bronchospasm, telangiectasia, and right-sided heart disease or failure. Coders need to know whether the carcinoid syndrome is present in patients with neuroendocrine tumors, given that ICD-9-CM has a provision to use additional codes to identify any associated endocrine syndromes, such as the carcinoid syndrome. If present, carcinoid syndrome (code 259.2) is a CC condition.

Be sure to query for the location of the carcinoid tumor in order to improve specificity. Not all carcinoid tumors are CCs.

CDI specialists may learn more about carcinoid tumors at the following Web site: www.aafp.org/afp/2006/0801/p429.html.
Benign carcinoid tumor of lung (p. 151)
The same advice as previously mentioned applies to this Coding Clinic entry—CDI specialists should query for the presence of MENS or associated endocrine syndromes, such as carcinoid syndrome, in patients admitted for a resection of a benign carcinoid tumor of the left lower lobe of the lung, if appropriate.

Diabetes with LOPS (p. 151)
This entry concerns a patient with diabetes mellitus type II and loss of protective sensation (LOPS). In this example, there was no overt linkage or documented cause and effect between the patient’s diabetes and the LOPS.

Coding Clinic advises that LOPS is a manifestation of the diabetic neuropathy and can be reported separately using 357.2 in addition to 250.6x, without need for query. Do not report 782.0 (disturbance of skin sensation) separately, since it is captured in the two previous codes.

“We don’t have to query to have the connection between LOPS and diabetic neuropathy made,” Doty emphasizes. “Coding Clinic does give permission to assume the link.”

Note, however, that diabetes mellitus and the generic symptom of numbness cannot be linked without explicit physician documentation or a positive response query—the situation described by Coding Clinic allows only for the above narrow assumption between LOPS and diabetes.

“Even so, CDI specialists should query the physician for consequences of the diabetes in all diabetic patients, since these can change the DRG,” Kennedy says.

Kennedy and Doty note that it’s also important to differentiate between peripheral polyneuropathy in diabetes (357.2) and peripheral autonomic neuropathies in diabetes (337.1). Autonomic neuropathies are manifested by wide swings in blood pressure, loss of temperature sensation, constipation, and/or impotence (often treated with Viagra). Peripheral neuropathies not otherwise specified often only demonstrate loss of two-point sensation in the lower extremities and may contribute to diabetic ulcers, Kennedy says.

If a patient is admitted with pneumonia and a peripheral autonomic neuropathy (337.1), the latter is a CC, whereas 357.2 is not. CDI specialists can learn more about autonomic neuropathies at the following Web site: www.mayoclinic.com/health/autonomic-neuropathy/DS00544.

Selection of obstetric principal diagnosis (p. 153)
For hospitals that use the APR-DRG system for quality measurement or contract with inpatient payers that reimburse using APR-DRGs (e.g., Blue Cross and Blue Shield of Massachusetts) or MS-DRGs (e.g., Blue Cross and Blue Shield of North Dakota) for their private payer population, CDI
specialists should take note that the ICD-9-CM Official Guidelines for Coding and Reporting pertaining to obstetric principal diagnosis selection have been revised. Refer to Section I.C.11.b.4.

Changes to the ICD-9-CM Official Guidelines for Coding and Reporting (p. 155)
Following are important changes to the ICD-9-CM Official Guidelines for Coding and Reporting, effective October 1, 2009.

Section I: Conventions, general coding guidelines, and chapter-specific guidelines
The ICD-9-CM Official Guidelines for Coding and Reporting added a line stating that the conventions and instructions of the classification take precedence over the guidelines. This emphasizes the hierarchy of ICD-9-CM, which follows below in order of primary authority (highest to lowest):

- The Index to Diseases and Injuries (Volume 1)
- The tabular listing (Volume 2)
- ICD-9-CM Official Guidelines for Coding and Reporting
- Coding Clinic

“CDI specialists may see something in Coding Clinic and run with it, but the lesson to be learned is that there is a hierarchy of precedence and authority,” Kennedy says. “They need to check with the current ICD-9-CM nosology and its guidelines, especially if the Coding Clinic advice is fairly old. Advice does change from time to time.”

Chapter-specific coding guidelines: Anemia associated with malignancy (p. 156)
The lesson here for CDI specialists is that anemia due to chemotherapy codes to 285.3, which is not a CC.

Anemia due to antineoplastic chemotherapy and antineoplastic chemotherapy-induced anemia are synonymous. Report them both with 285.3. Report 285.22 for anemia secondary to a malignancy, a form of chronic anemia. When both conditions occur in the same patient—and a physician properly documents both—report codes 285.3 and 285.22.

It’s also important for CDI specialists to know that the ICD-9-CM table has an exclusion for the pancytopenia code (284.1)—pancytopenia due to chemotherapy (any drug)—which codes to 284.89, an MCC. If neutropenia and thrombocytopenia coexist with drug- or chemotherapy-induced anemia, it becomes a CDI opportunity.

“The documentation strategy is to identify the clinical indicators that support pancytopenia, which are in the laboratory notes, and the need for the physician to recognize it and link it to its underlying cause,” Kennedy says.
Clinical indicators for pancytopenia include all of the following:

- Thrombocytopenia: Platelet count less than 150,000
- Neutropenia: Absolute neutrophil count (total white count multiplied by the percentage of neutrophils and bands) less than 1,500
- Anemia: Hematocrit less than 32

Note that pancytopenia must be qualified as an additional diagnosis (e.g., be treated, monitored, etc.) before the CDI specialist queries for this diagnosis. CDI specialists should ask the physician to break out which component of the pancytopenia he or she addressed (e.g., thrombocytopenia) so it may be coded in addition to the pancytopenia code, Kennedy says.

*Coding Clinic*, third quarter 2005, pp. 11–12, provides an excellent reference, Kennedy notes. “In reading this, one must remember that the codes of 284.8 were expanded in 2007 to include 284.81 and 284.89,” he says. “CDSs should discuss this reference with their coding staff and oncologists.”

Chapter-specific coding guidelines: Secondary diabetes mellitus due to pancreatectomy (p. 157)

The *ICD-9-CM Official Guidelines for Coding and Reporting* state that in the event a patient has a pancreatectomy and also has diabetes, coders should also assign a code from subcategory 249 and code V45.79, which can be potential CCs and MCCs. Previously, coders reported 251.3; this is no longer allowed.

Chapter-specific coding guidelines: Influenza due to certain identified viruses (p. 158)

The *ICD-9-CM Official Guidelines for Coding and Reporting* state that influenza due to avian influenza or the H1N1 influenza virus cannot be coded when documented as suspected, possible, or probable at the time of discharge, which is an exception to the rule of uncertain diagnoses from the inpatient guidelines.

Kennedy notes that there are different coding and sequencing rules for H1N1, avian, and influenza that is not otherwise specified as avian or H1N1. He encourages CDI specialists to look at the codes for 487 and 488 in the ICD-9-CM table and to apply DRG logic to these code assignments.

For example, if a patient is admitted with unspecified influenza and staphylococcal pneumonia, the principal diagnosis code is always 487.0—Influenza with pneumonia—which groups to MS-DRG 195 (relative weight 0.7095). However, if the patient has H1N1 influenza with staphylococcal pneumonia, coding rules allow a coder to sequence either 488.1 (MS-DRG 153—relative weight 0.6084) or 482.40 (MS-DRG 179—relative weight 1.0088) as the principal diagnosis.

Consequently, if a patient has influenza, it is vital for the physician to clarify the type.
Chapter-specific coding guidelines: The postpartum and peripartum periods (p. 159)

The *ICD-9-CM Official Guidelines for Coding and Reporting* state that if an obstetrical patient has puerperal sepsis, a coder would not assign 995.91 (sepsis), since code 670.2x (puerperal sepsis) is inclusive of this condition. However, if the patient has puerperal severe sepsis, a coder would report additional code 995.92 (severe sepsis).

Kennedy notes that reporting 995.92 will increase the severity of illness (SOI) of a case in the APR-DRG system from an SOI of 2 to a 3.

Chapter-specific coding guidelines: Injury and poisoning (p. 160)

The *ICD-9-CM Official Guidelines for Coding and Reporting* state that when a reaction results from the interaction of a drug(s) and alcohol, it is classified as poisoning, not just a simple adverse reaction to a medication.

For example, if a patient is taking a prescription and drinks a beer and a reaction results, even though the prescribed drug was used appropriately and the alcohol was not abused, the case would still be coded as a poisoning.

“CDSs should be on the lookout for adverse drug reactions and work with their providers to clarify if these are reactions to drugs that were properly administered or taken in a purposeful or accidental overdose,” Kennedy says.

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