It’s time to review Coding Clinic, 3rd Quarter and 4th Quarter 2010, as we partner with physicians to clarify inconsistent, incomplete, imprecise, conflicting, and illegible clinical documentation in the medical record.

**Metastasis of a lung cancer into another lobe of the lung (3rd Quarter, p. 3)**

In an interesting scenario, Coding Clinic was asked how to code a primary lung cancer that metastasized into another lobe of the lung. The question placed special emphasis on whether the second lesion would be coded as a primary lesion of the lung or as a metastasis.

Coding Clinic stated that if the physician documents that the second lung cancer is a metastasis, it would receive an additional code as a metastasis, not as a primary lesion. Coding Clinic did emphasize that one cannot assume that a second lesion is a metastasis or a primary cancer of both lungs, thus coders and CDI specialists should query when two lesions exist in order to add precision to the diagnostic statement.

This advice is interesting, given how ICD-9-CM addresses primary lung lesions:

- **162** Malignant neoplasm of trachea, bronchus, and lung
  - 162.0 Trachea
    - Cartilage of trachea
    - Mucosa of trachea
  - 162.2 Main bronchus
    - Carina
    - Hilus of lung
  - 162.3 Upper lobe, bronchus or lung
  - 162.4 Middle lobe, bronchus or lung
  - 162.5 Lower lobe, bronchus or lung
  - 162.8 Other parts of bronchus or lung
    - Malignant neoplasm of contiguous or overlapping sites of bronchus or lung whose point of origin cannot be determined
  - 162.9 Bronchus and lung, unspecified
- **197** Secondary malignant neoplasm of respiratory and digestive systems

Excludes: lymph node metastasis (196.0–196.9), secondary neuroendocrine tumor of liver (209.72), secondary neuroendocrine tumor of respiratory organs (209.79)
Never forget that ICD-9-CM diagnosis codes can only be assigned once. If two primary lesions occur in the same lobe, a coder may only report one code. CDI specialists should note that any metastatic lesions are CCs.

Ventilator weaning hours (3rd Quarter, pp. 3–4)

ICD-9-PCS categorizes mechanical ventilation codes in the following manner:
- 96.70 Continuous invasive mechanical ventilation of unspecified duration
- 96.71 Continuous invasive mechanical ventilation for less than 96 consecutive hours
- 96.72 Continuous invasive mechanical ventilation for 96 consecutive hours or more

Given that some diagnosis-related groups differentiate between invasive mechanical ventilation for less than 96 consecutive hours and invasive mechanical ventilation for 96 consecutive hours or more, it is critical to know how invasive mechanical ventilation is defined, how ventilator hours are counted, and how to clarify the physician’s intent, especially during the weaning process.

First, let’s read how ICD-9-PCS counts ventilator hours:

Endotracheal intubation
- To calculate the number of hours (duration) of continuous mechanical ventilation during a hospitalization, begin the count from the start of the (endotracheal) intubation. The duration ends with (endotracheal) extubation.
- If a patient is intubated prior to admission, begin counting the duration from the time of the admission.
- If a patient is transferred (discharged) while intubated, the duration would end at the time of transfer (discharge).
- For patients who begin on (endotracheal) intubation and subsequently have a tracheostomy performed for mechanical ventilation, the duration begins with the (endotracheal) intubation and ends when the mechanical ventilation is turned off (after the weaning period).

Tracheostomy
- To calculate the number of hours of continuous mechanical ventilation during a hospitalization, begin counting the duration when
mechanical ventilation is started. The duration ends when the mechanical ventilator is turned off (after the weaning period).

- If a patient has received a tracheostomy prior to admission and is on mechanical ventilation at the time of admission, begin counting the duration from the time of admission.
- If a patient is transferred (discharged) while still on mechanical ventilation via tracheostomy, the duration would end at the time of the transfer (discharge).

*Coding Clinic*, 3rd Quarter 2010, pp. 3–4, clarifies that you should count the period of weaning during the process of withdrawing the patient from ventilatory support. The duration includes the time the patient is on the ventilator, the weaning period, and ends when the mechanical ventilation is turned off (after the weaning period).

This concept was pertinent when a patient was transferred from a short-term acute care hospital to a long-term acute care hospital (presumably for the purpose of weaning the patient from the ventilator) and, at the time of admission, was on a T-piece and later placed on a ventilator. *Coding Clinic* allowed for the ventilator hours to be counted at the time of admission, not the time the patient was placed on the ventilator later that evening, deeming that the patient was in the weaning process at the time of admission even though he or she was on a T-piece.

Although not mentioned in this *Coding Clinic*, the following principles apply when assigning mechanical ventilator codes:

- **4th Quarter 2008, pp. 187–190:** This advice outlined changes in ICD-9-PCS on October 1, 2008, that differentiated between invasive and noninvasive mechanical ventilation. These include the following:
  - **96.7 Invasive mechanical ventilation**
    - BiPAP delivered through endotracheal tube or tracheostomy (invasive interface)
    - CPAP delivered through endotracheal tube or tracheostomy (invasive interface)
    - Endotracheal respiratory assistance
    - Invasive positive pressure ventilation (IPPV)
    - Mechanical ventilation through invasive interface
    - That by tracheostomy
    - Weaning of an intubated (endotracheal tube) patient
  - **93.90 Noninvasive mechanical ventilation**
    - Bi-level airway pressure
    - BiPAP without (delivery through) endotracheal tube or tracheostomy
    - CPAP without (delivery through) endotracheal tube or tracheostomy
    - Mechanical ventilation not otherwise specified
    - Noninvasive positive pressure ventilation (NIPPV)
• Noninvasive PPV
• NPPV
• That delivered by noninvasive interface:
  - face mask
  - nasal mask
  - nasal pillow
  - oral mouthpiece
  - oronasal mask

2nd Quarter 2006, p. 8: This issue of Coding Clinic states that any postoperative patient receiving invasive mechanical ventilator care for more than two days must have an appropriate 96.7 code assigned. Based on Coding Clinic, 3rd Quarter 2004, p. 11, the number of hours starts at the time of intubation.

Iatrogenic cerebrovascular infarction (3rd Quarter, p. 5)
Citing a little-known rule from the ICD-9-CM Official Guidelines for Coding and Reporting, Coding Clinic states that a coder should report complication code 997.02 (Iatrogenic cerebrovascular infarction or hemorrhage) as well as code E934.4 (Drugs, medicinal and biological substances causing adverse effects in therapeutic use) in the instance of a patient whose hemorrhagic conversion was caused by tPA therapy.

Hospitals sensitive to their complications indexes should be aware of this guidance, which follows the official advice in the ICD-9-CM Official Guidelines for Coding and Reporting.

Note that code 997.02 does not affect MS-DRG assignment, since 431 (Intracerebral hemorrhage) already serves as the MCC when 434.91 (Cerebral artery occlusion, unspecified) is reported as the principal diagnosis.

Remember that coders and CDI specialists cannot assume that other adverse effects from medications can be coded as complications.

Transtracheal oxygen therapy (3rd Quarter, p. 6)
In this scenario, a patient with COPD underwent placement of a catheter for transtracheal oxygen, otherwise known as a Fastrach™ transtracheal or “micro-trach” procedure. The procedure involved a “punch” to gain access to the trachea and the placement of a stent as to allow for the oxygenation catheter. You can learn more about this procedure on the Medscape® Today website at www.medscape.com/viewarticle/455720_19.

Coding Clinic recommended that the coder report 31.99 (Other operations of trachea) for the procedure, given that there is a listing in the Alphabetic Index to Procedures for insertion of a transtracheal catheter for oxygenation. Note that it is important to differentiate these procedures from a tracheostomy, especially a temporary percutaneous dilatational tracheostomy or a tracheotomy for assistance in breathing. This codes to 31.1. The following chart demonstrates the differences between 31.99 and 31.1:
The chart at right demonstrates the differences between 31.99 and 31.1.

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Principal Dx</th>
<th>Base DRG</th>
<th>Secondary Dx</th>
<th>Relative weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>31.99—Other procedure of larynx</td>
<td>MDC 4</td>
<td>Other respiratory system OR procedure</td>
<td>No CC/MCC</td>
<td>1.3008</td>
</tr>
<tr>
<td></td>
<td>MDC 18</td>
<td>Infectious &amp; parasitic disease with OR procedure</td>
<td>No CC/MCC</td>
<td>1.3797</td>
</tr>
<tr>
<td></td>
<td>Other MDC</td>
<td>Extensive OR procedure unrelated to the principal diagnosis</td>
<td>No CC/MCC</td>
<td>1.7767</td>
</tr>
<tr>
<td>31.1—Temporary tracheostomy w/o major OR procedure</td>
<td>All but face, mouth &amp; neck</td>
<td>Tracheostomy with MV 96+ hrs or PDX except face, mouth &amp; neck w/o major OR procedure</td>
<td>All</td>
<td>11.2403</td>
</tr>
<tr>
<td>31.1—Temporary tracheostomy w/ major OR procedure</td>
<td>All but face, mouth &amp; neck</td>
<td>Tracheostomy with MV 96+ hrs or PDX except face, mouth &amp; neck w/ major OR procedure</td>
<td>All</td>
<td>18.1239</td>
</tr>
</tbody>
</table>

In these instances, CDI specialists should also be on the lookout for clinical indicators of acute or chronic hypoxemic respiratory failure.

**Skin grafts and debridement (3rd Quarter, pp. 7–8)**

*Coding Clinic, 3rd quarter 2010, includes two scenarios of patients receiving skin grafts, including Apligraf® and a Graft Jacket®. Coding Clinic states that 86.67 (Dermal regenerative graft) should be reported in both instances, resulting in an MS-DRG assignment of 575.*

*Coding Clinic* does not recommend reporting additional non-excisional debridement codes in these instances.

**Transbronchial needle aspiration of the lymph node (3rd Quarter, p. 9)**

This entry—which recommends code 40.11, Biopsy of lymphatic structure, for a transbronchial needle aspiration (TBNA) of the mediastinal lymph node using a Wang needle—is important only in that CDI specialists should note that this procedure is separate and distinct from an endobronchial needle biopsy of lung tissue.
TBNA using a Wang needle has CDI opportunities of which physicians, coders, and CDI specialists should be aware. A number of Coding Clinic entries address assignment of the following procedure codes:

- 33.24 Closed [endoscopic] biopsy of bronchus
- 33.27 Closed endoscopic biopsy of lung
- 40.11 Biopsy of lymphatic structure

Coding Clinic, 2nd Quarter 2009, pp. 16–17, states that transbronchoscopic fine needle aspiration biopsy (Wang needle aspiration biopsy) is captured with code 33.24 and should not be coded as transbronchoscopic lung biopsies, even if lung tissue is seen on the pathology report, unless that was the intent of the procedure. The operative report should show that fluoroscopy was used to guide the placement of the needle. If the documentation does not specify the intent of the use of TBNA, a CDI specialist must query.

Pacemaker interrogation with controlled sick sinus syndrome (3rd Quarter, p. 9)

This entry states that it is not appropriate to assign a code for sick sinus syndrome when a patient with that chronic condition has a previously placed pacemaker that is only interrogated during the hospitalization. This advice is supported by a previous Coding Clinic, 5th Issue 1993, p. 12, which states that cardiac rhythms addressed with chronic cardiac pacemakers are not to be coded if no attention or treatment is provided to the condition or the device.

Note that this guidance does not apply if the rhythm is being treated with medication (e.g., amiodarone, sotalol) or if the pacemaker is being implanted for the first time. In these instances, a coder or CDI specialist should query for the diagnosis to accompany the medication or reason for pacing, and it may be reported separately.

Incision and drainage of ulceration (3rd Quarter, p. 11)

This entry states that an excisional debridement of the fascia to the bone should be reported with 83.39 (Excision of lesion of other soft tissue) and not a code for excisional debridement of the bone.

Some hospitals have grown wary of reporting excisional debridement codes due to heavy scrutiny by Recovery Audit Contractors, but this entry reports an appropriate instance of the code. Note that an extensive excisional debridement is not integral to an incision and drainage and may be coded separately, per Coding Clinic, 3rd quarter 2008, pp. 8–9.

Low anterior resection vs. sigmoid colectomy (3rd Quarter, p. 12)

This Coding Clinic entry provides an excellent example in that although a physician may label a procedure in one way, how he or she describes the procedure in the operative note may warrant its coding in another way. In this circumstance, a colorectal surgeon describes the resection of the sigmoid...
colon with a “little bit” of descending colon and a “little bit” of the rectum, yet he or she labeled this as a “low anterior resection,” which is generally thought to be a rectal resection. You can read an interesting description of this procedure on the Intuitive Surgical® website at http://tinyurl.com/DaVinciLAR.

*Coding Clinic* deemed that “a little bit of rectum” does not qualify the procedure as a rectal resection, even though it was labeled as a low anterior resection. Note that the term “low anterior resection” does not have an entry in the ICD-9-PCS index to procedures, thus coders and CDI specialists must read operative reports carefully to determine what procedure code is to be assigned.

**Pulmonary hypertension vs. systemic hypertension**  
(3rd Quarter, pp. 12–13)  
This entry affirms that both chronic pulmonary heart disease and hypertensive chronic kidney disease may be reported together when a physician diagnoses both conditions.

**End-stage renal disease and acute kidney failure**  
(3rd Quarter, p. 15)  
In what is perhaps the most unusual entry in *Coding Clinic*, 3rd quarter 2010, the publication states that acute kidney failure is not an acute exacerbation of chronic kidney failure and, thus, as two separate and distinct conditions (per *Coding Clinic*), both may be coded if documented by the provider. *Coding Clinic* extrapolated this advice to end-stage renal disease (ESRD) as well.

Some in the medical community believe that this guidance does not reflect clinical reality, but others believe it does. Medicare defines ESRD as a kidney impairment that is irreversible and permanent and requires either a regular course of dialysis or kidney transplantation to maintain life. Some physicians do not believe that acute renal failure can occur in the setting of irreversible and permanent kidney impairment. We now have *Coding Clinic*’s stance on the controversial issue.

Note that ESRD loses its status as an MCC if acute kidney failure is reported as the principal diagnosis. That’s because ESRD is on the CC and MCC exclusion list. However, 584.9 (acute kidney failure) has a severity of illness (SOI) of 4 (severe) in the APR-DRG system, so this new advice would more than likely affect SOI/ROM scores.

**Angioplasty of precerebral vs. intracerebral arteries**  
(3rd Quarter, pp. 17–18)  
Code assignment is guided by the Alphabetic Index to Diseases and the Alphabetic Index to Procedures, even if it does not make clinical sense. In this entry, *Coding Clinic* addresses the coding of angioplasty and stent placement of the basilar artery and the cavernous sinus of the carotid artery, noting that radiology considers these to be intracerebral vessels. *Coding Clinic*
noted that the Index to Procedures classifies these as extracranial vessels, even if radiologists think otherwise. Since CMS governs Volume 3 of ICD-9-CM, it would have to change the classification of angioplasty and stent placement if these are to be considered as intracerebral vessels.

The Alphabetic Index to Procedures classifies these procedures as follows:

- Angioplasty
  - percutaneous transluminal (balloon) (single vessel)
    - basilar 00.61
    - carotid 00.61
    - cerebral (intracranial) 00.62
    - cerebrovascular
      - cerebral (intracranial) 00.62
      - precerebral (extracranial) 00.61
    - carotid 00.61
    - precerebral (extracranial) 00.61
    - vertebral 00.61

Although one may disagree, the guidance is what it is.

**Palliative care (3rd Quarter, p. 18–19)**

This entry states that a coder should assign V66.7 (Encounter for palliative care) as an additional diagnosis in the instance of an 88-year-old male admitted to the ICU following a massive intracerebral hemorrhage and subsequently the physician documented comfort care and pain control.

CDI specialists should also know that there is a new code for “do not resuscitate,” or DNR (V49.86). V49.86 has a present-on-admission (POA) status assigned to it, so if a DNR patient is admitted, CDI specialists should help ensure that a POA of Y is properly noted in the chart.

This entry also serves as a reminder that CDI specialists should ask physicians to document the mechanism of patient death, since not reporting all appropriate diagnoses for patients on palliative care can result in a low SOI/ROM score for a patient who expires.

**Hypertensive urgency and emergency (4th Quarter, p. 135)**

One of the most vexing issues with ICD-9-CM is the clinical documentation and coding of uncontrolled hypertension. There is absolutely no consistency in the labels or definitions of terms physicians use to describe and diagnose the various stages of uncontrolled hypertension. Labels may include:

- Extremely high blood pressure
- Poorly controlled hypertension
- Uncontrolled hypertension
- Hypertensive crisis
When Coding Clinic was asked how to assign a code for hypertensive urgency, it advised that a physician query was necessary to determine the specific type of hypertension. Coding Clinic encouraged the use of the Hypertension table in the Alphabetic Index. Given that there are no entries in the Alphabetic Index for hypertensive emergency, this advice should apply to this term as well.

It is beyond the scope of this article to address the various definitions of uncontrolled hypertension. Suffice it to say that some believe accelerated or malignant hypertension require a moderate or malignant hypertensive retinopathy and some do not. The following references may be beneficial for additional research:


Note that there are many new codes and some changes to the ICD-9-CM guidelines in Coding Clinic, 4th Quarter 2010. If you do not have a subscription, please obtain a copy of the new Coding Clinic from your coding department and read these carefully.