Know when to report secondary diagnoses

A patient’s medical record could include a laundry list of diagnoses, but not all of these conditions may be reportable.

Coders must determine when they can report conditions as “other” secondary diagnoses and when they must simply leave them off the claim entirely.

Why is this important? Coding diagnoses that don’t affect the current admission or that don’t fit reporting criteria could affect data quality, patient acuity, and reimbursement, says Gloryanne Bryant, RHIA, CCS, CCDS. Bryant is regional managing director of HIM, NCAL revenue cycle, at Kaiser Foundation Health Plan, Inc. & Hospitals in Oakland, CA.

It also could leave a hospital vulnerable to a RAC audit, particularly when the diagnoses in question are CCs or MCCs that yield a higher-weighted DRG. However, underreporting secondary diagnoses can also be detrimental in terms of quality and reimbursement, so hospitals must find a compliant balance between the two, says Bryant.

Know the definitions, guidelines

The Uniform Hospital Discharge Data Set defines “other diagnoses” as “all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded.”

For reporting purposes, the ICD-9-CM Official Guidelines for Coding and Reporting define “other diagnoses” as additional conditions that affect patient care because they require one or more of the following:

- Clinical evaluation
- Therapeutic treatment
- Diagnostic procedures
- Extended length of hospital stay
- Increased nursing care and/or monitoring

Coders must remember that reportable secondary diagnoses must meet only one of the five previously listed criteria, says Bryant. However, applying the criteria may be easier said than done, she says.

“Clinical evaluation can be challenging because it’s sometimes up for interpretation, and coders need to apply some basic logic,” says Bryant. Coders generally should look for implicit information that suggests a
physician is applying clinical criteria to evaluate a condition. This information won’t always be explicitly documented, she says. Ask the following questions:

➤ Did the physician document ordering a consultation or additional test? If so, this could indicate that the physician is clinically evaluating the condition to which the consultation or test applies.

➤ Did the physician frequently document a diagnosis in the daily progress notes? This could indicate the physician is watching or monitoring a condition.

Many coders struggle with reporting anemia when it’s documented in the past medical history and the remainder of the record doesn’t include explicit evaluation or treatment, says Laura Doty, RHIT, director of FTI Healthcare in Atlanta. Physicians might not explicitly document treatment of the condition, but they may monitor a patient’s hemoglobin or hematocrit at least twice during a hospital stay. “Some coders hesitate to pick this up, but the physician is monitoring the anemia to see whether the condition has worsened. This will qualify it as a secondary diagnosis,” Doty explains.

Increased nursing care or extended length of stay may also confuse coders. “A coder may not know how much increased time is involved, so he or she may not pick up the code,” she says. For example, coders should always report morbid obesity because this condition always increases nursing time, she says. When in doubt about whether a condition increases nursing time or length of stay, coders should ask a CDI specialist or physician advisor for clarification, she says.

Remember that just because a physician lists a diagnosis doesn’t mean it’s relevant to the current admission, says Doty. For example, documentation of “frequent or chronic urinary tract infections [UTI]” may be important—and even reportable in some circumstances—but not for a hospital stay during which a patient with chronic UTIs neither has a UTI upon admission nor develops one during the stay, she says. Remember this advice going forward because RACs will assess whether otherwise reportable secondary diagnoses are actually relevant to the current hospital admission, she explains.

Note chronic conditions

Coders should always report certain chronic conditions, even in the absence of intervention or further evaluation, says Bryant. “The mere [presence of these conditions] will affect patients for the rest of their lives or most of their lives and require continuous clinical monitoring and evaluation all of the time,” she explains.

Coding Clinic, 2nd quarter 2000, pp. 20–21, says that coders should always report the following chronic conditions when they are documented:

➤ Hypertension

➤ Parkinson’s disease

➤ Chronic obstructive pulmonary disease (COPD)
➤ Diabetes
➤ Asthma
➤ Emphysema

However, this list isn’t all-inclusive, and there are other chronic conditions that coders may need to report when documented, says Bryant. Examples include cystic fibrosis, systemic lupus erythematosus, and multiple sclerosis.

When it’s unclear whether an otherwise chronic condition affects the current admission, coders should seek clarification from a CDI specialist or physician advisor, or query a physician, she says.

**Understand abnormal findings**

In accordance with ICD-9-CM guidelines, coders should not report abnormal findings (laboratory, x-ray, pathologic, or other diagnostic results) unless a provider indicates their clinical significance. When findings are outside the normal range—and the attending provider has ordered other tests to evaluate the condition or prescribed treatment—coders should query the provider to determine whether they should report the abnormal finding.

Coders in an inpatient setting may report abnormal findings only when physicians can’t arrive at a related diagnosis and the abnormal finding is diagnostically significant, says Bryant. “Coders should never report a code based on an abnormal finding alone,” she explains. “The finding must be important enough that the doctor lists it in a diagnostic statement within the medical record. Otherwise, coders can’t interpret it to be reportable.”

Abnormal findings without explicit documentation of conditions related to those findings may present coders with opportunities to query physicians, says Bryant. “We don’t want to be overzealous with querying every little abnormal finding,” she says. However, coders should be on the lookout for ongoing laboratory evaluations that may point to a more definitive diagnosis or condition. For example, a physician performs a series of blood tests to evaluate an asymptomatic patient’s low hemoglobin. If the finding is outside the normal range, coders may need to query the physician for an associated diagnosis, she says.

**Don’t forget V codes**

The ICD-9-CM guidelines say that coders may report history codes (V10–V19) as secondary diagnoses if the historical condition or family history affects current care or influences treatment.

A personal history of cancer will always be relevant, and some state registries may require hospitals to report it, says Doty. Smoking may also influence a patient’s care and the medical decision-making process, she explains.

Determining which V codes influence current care or treatment can be confusing. Coders acquire this skill with experience and by expanding their clinical knowledge, says Bryant. Coders also can review nursing assessment documentation because this can provide valuable information about a potential condition for which a query may be necessary, she says.

**Advocate for better documentation**

Thorough documentation can go a long way in assisting coders with compliantly coding a record. This couldn’t be more true for the discharge summary. ICD-9-CM guidelines say that if a provider documents the diagnosis at

> continued on p. 4

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**Have you looked at your PEPPER lately?**


As of this date, hospitals with a My QualityNet account will receive reports that will include several new target areas based on RAC demonstration and expansion project findings, interpretive guidance, suggested interventions, and improved labeling. PEPPERS also will be available for critical access hospitals, inpatient psychiatric facilities, and inpatient rehabilitation facilities this year.

Access the 2011 PEPPER distribution schedule at www.pepperresources.org/PEPPER/PEPPERDistribution.aspx. Access the expanded list of target areas along with the new and improved target area worksheet at www.pepperresources.org/TrainingResources/ShorttermAcuteCareHospitals.aspx. Look under “Redesigned PEPPER.”
Secondary diagnoses  < continued from p. 3

the time of discharge as “probable,” “suspected,” “likely,” “questionable,” “possible,” “still to be ruled out,” or other similar terms indicating uncertainty, coders may report the condition as if it existed or was established.

Coders must remember that these uncertain conditions must be documented at the time of discharge for coders to report them, says Bryant.

In accordance with ICD-9-CM guidelines, coders should not report resolved conditions or diagnoses that were not treated and resolved during the admission. For example, a physician documents in the discharge summary that a patient had a “recent UTI.” The UTI occurred three months ago; coders probably shouldn’t report it because the physician may have documented it simply for continuity of care with other providers, says Doty. Coders should look for documentation of treatment directed toward the UTI and whether it was POA before reporting it.

Similarly, a physician documents “pneumonia” in the past medical history—which indicates a previous encounter or outpatient treatment without a need for ongoing treatment. The patient currently is admitted for exacerbation of COPD. Don’t report the pneumonia; it’s not pertinent to the current admission, says Doty.

Coders may need to work directly with CDI specialists or their physician advisor to address cases in which the documentation is unclear regarding whether the condition is resolved or ruled out. Unclear documentation is an unfortunate reality that many coders face when physicians suspect a condition, document it initially, rule it out mentally (but fail to document this), and then simply stop documenting the condition entirely in the record, says Doty. “They’ve moved on, and as the coder, you’re left hanging,” she explains.

Ask these questions

Consider the following questions before reporting secondary diagnoses:

➤ Does documentation support assignment of the diagnosis in accordance with the reporting guidelines? If documentation supports assignment, is the diagnosis eligible for reporting as a secondary diagnosis (i.e., does it meet reporting criteria)?

➤ Does documentation include clinical indicators that justify a query for a more specified or definitive diagnosis?

➤ When documentation is unclear regarding the relevance of a secondary diagnosis to the current admission, is a physician advisor or CDI specialist available to provide clinical insight regarding how a condition may affect patient care?

Always remember to dig deeply in documentation whenever you assign the POA indicator

Don’t default to ‘N,’ especially when reporting HACs

How often have you encountered this frustrating, yet all-too-common scenario?

You’re coding a record, and the documentation of a patient’s stage III pressure ulcer isn’t clear enough for you to determine whether the ulcer is POA. More importantly, what do you do?

Unfortunately, some coders simply default to POA indicator “N” instead of querying the physician, says Glenn Krauss, RHIA, CCS, CCS-P, CPUR, C-CDI, CCDS, an independent HIM consultant in Madison, WI. However, the goal should be reducing the number of “Ns”—not accepting them as fact, Krauss says.

“Every case that’s not POA should be reviewed by a physician,” he says. “You may be sending a wrong signal to Medicare, and the immediate effect is that you’re forgoing reimbursement to which you may be entitled.”
The good news is that an overwhelming percentage of high-volume HACs have been reported with POA indicator “Y” when listed as a secondary diagnosis, according to the FY 2011 IPPS final rule. (See chart at bottom right for more information.) Those HACs with the highest frequency as a secondary diagnosis include:

- Falls and trauma—153,284 (96.1% are POA)
- Pressure ulcers, stages III and IV—105,092 (98.7% are POA)
- Poor glycemic control—14,303 (96.8% are POA)
- Catheter-associated urinary tract infection—14,089 (83.2% are POA)
- Vascular catheter–associated infection—6,933 (62.6% are POA)

Hospitals should strive for documentation that jives with the CMS data and justifies assignment of POA indicator “Y” when appropriate, says Krauss.

CDI specialists should focus on these high-volume HACs and request clarification concurrently to avoid coding delays and ensure proper POA assignment, he explains.

Coders also can help ensure compliance, says Judith Sturgeon, CCS, clinical coding and reimbursement compliance manager at Harris County Hospital District in Houston. “Coders need to be aware that they do have some clinical leeway, and they do need to go back to the point of care—the ER documentation and nursing notes—to look at the symptoms, the presentation, and the physical exam on admission,” she explains.

When in doubt, always refer to the record to review any laboratory tests that the patient may have undergone. For example, when was the first urine sample drawn, and were white blood cells present? If the laboratory test occurred upon admission and white blood cells were present, this may indicate the patient has a catheter-associated UTI POA. Coders can’t diagnose, but they can use laboratory test values or other documentation clues as a basis for a query, says Sturgeon.

POA status of current HACs for discharges occurring October 2008 through September 2009

<table>
<thead>
<tr>
<th>Selected HAC</th>
<th>Percent of Admissions</th>
<th>Percent of Admissions</th>
<th>Percent of Admissions</th>
<th>Percent of Admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>POA = N</td>
<td>POA = E</td>
<td>POA = Y</td>
<td>POA = W</td>
</tr>
<tr>
<td>1. Foreign Object Retained After Surgery (FCR)</td>
<td>441</td>
<td>189</td>
<td>42.0</td>
<td>0</td>
</tr>
<tr>
<td>2. Air Embolism (EMB)</td>
<td>33</td>
<td>24</td>
<td>73.7</td>
<td>0</td>
</tr>
<tr>
<td>3. Blood Incompatibility (BIC)</td>
<td>28</td>
<td>8</td>
<td>28.6</td>
<td>0</td>
</tr>
<tr>
<td>4. Pressure Ulcer Stage III &amp; IV (PUC)</td>
<td>105,092</td>
<td>1,311</td>
<td>1.2</td>
<td>96</td>
</tr>
<tr>
<td>5. Falls and Trauma (BIC &amp; PUC)</td>
<td>153,284</td>
<td>5,068</td>
<td>3.3</td>
<td>270</td>
</tr>
<tr>
<td>6. Catheter-Associated UTI (CAUTI)</td>
<td>14,089</td>
<td>2,955</td>
<td>20.9</td>
<td>10</td>
</tr>
<tr>
<td>7. Vascular Catheter–Associated Infection (VACI)</td>
<td>6,933</td>
<td>2,555</td>
<td>36.5</td>
<td>22</td>
</tr>
<tr>
<td>8. Poor Glycemic Control (DMC)</td>
<td>14,303</td>
<td>435</td>
<td>3.0</td>
<td>10</td>
</tr>
<tr>
<td>9. Surgical Site Infection, Methicillin-Resistant Staphylococcus (SSRI)</td>
<td>55</td>
<td>26</td>
<td>47.3</td>
<td>0</td>
</tr>
<tr>
<td>10. Surgical Site Infection, Certain Orthopedic Procedures (SSID)</td>
<td>280</td>
<td>157</td>
<td>60.9</td>
<td>1</td>
</tr>
<tr>
<td>11. Surgical Site Infection Following Bariatric Surgery for Obesity (SSIB)</td>
<td>17</td>
<td>15</td>
<td>88.2</td>
<td>0</td>
</tr>
<tr>
<td>12. Pulmonary Embolism &amp; Deep Vein Thrombosis (PE &amp; DVT)</td>
<td>2,177</td>
<td>2,090</td>
<td>96.5</td>
<td>74</td>
</tr>
</tbody>
</table>

POA indicator  < continued from p. 5

Coding Clinic, 4th quarter 2008, pp. 324–328, provides several clinical examples of how to assign each indicator and several that demonstrate when querying physicians is appropriate. For example, the nursing initial assessment upon admission includes documentation of the presence of a decubitus pressure ulcer, but there is no mention of the decubitus pressure ulcer in the physician documentation until several days after admission. In this situation, coders should query the physician to determine whether the ulcer was POA.

However, before coders can assign an accurate POA indicator, they must ensure that the HAC or condition is accurately reported, says Krauss.

For example, when a patient with a vascular catheter has positive blood cultures that are documented as sepsis or sepsis with bacteremia, don’t assume the infection is caused by the vascular catheter. Some patients can develop sepsis from an infection in the gut. This frequently occurs in patients with severe cases of long-standing diverticulitis or a duodenal ulcer. Coders must understand the organism being cultured and where it commonly resides.

To ensure compliance, consider drafting a POA policy that addresses the following:

➤ The circumstances in which coders will query for the POA indicator. It may not be feasible to query when the POA indicator doesn’t affect the DRG assignment, but coders should know when to query and which clinical indicators may help prompt a query, says Sturgeon.

➤ The role that CDI specialists will play in accurately capturing the POA, particularly as it pertains to HACs.

➤ The process for cases in which the POA indicator is “N.” Minimally, this information should be sent to the quality committee, and a physician should review it concurrently, says Krauss.

➤ The definitions and clinical criteria that critical care physicians and other providers use for each HAC. Asking providers to define each HAC and describe the clinical criteria they use to determine a diagnosis can help coders better identify HACs and craft more clinically sound queries, says Krauss. ■
ICD-10-PCS
Understand medical, surgical root operations

When ICD-10 takes effect October 1, 2013, the number of inpatient procedure codes will grow exponentially—from ICD-9-CM’s 3,860 codes to a staggering 72,131, according to the 2011 version.

“In my opinion, this is the biggest change in healthcare since the implementation of DRGs back in the early ‘80s,” says Shannon E. McCall, RHIA, CCS, CCS-P, CPC, CPC-I, CEMC, CCDS, director of HIM and coding at HCPro, Inc., in Danvers, MA.

Unlike ICD-9-CM procedure codes, ICD-10-PCS codes will be far more specific, expandable, and clinically logical. “It will hopefully improve communications with physicians because it will mirror the clinical aspects of operative notes as opposed to [requiring physicians to] use alternate phrasing based on the ICD-9-CM Manual,” says McCall.

Understand the ICD-10-PCS table

However, these improvements don’t imply that the new coding system won’t challenge coders. It will require far more detailed knowledge of anatomy and physiology, and coders will need to think in a completely different manner when assigning a seven-character ICD-10-PCS code, says McCall.

An alphabetic index to identify the root operation or a composite term of the root operation exists within ICD-10-PCS, but it only drives coders to a specific ICD-10-PCS table. Coders then must use the table to formulate a complete seven-character code. Access the complete ICD-10-PCS table at www.cms.gov/ICD10/Downloads/2011_Code_Tables_and_Index.pdf.

Take a step-by-step approach to learning

A step-by-step approach to code assignment is helpful when trying to understand the complexity of ICD-10-PCS.

➤ Step one: Determine the first character, which denotes the general category of procedure. (The remainder of this article focuses on codes derived from the first character “0,” which denotes medical and surgical procedures.)

➤ Step two: Determine the second character, which denotes the specific body system to which the procedure applies.

➤ Step three: Determine the third character, which denotes the root procedure. Within the medical and surgical section of codes, there are 31 potential root operations, each of which is based on the objective of the procedure. These 31 root operations are organized into the following nine groups:

- Those that take out some or all of a body part
- Those that take out solids/liquids/gases from a body part
- Those involving cutting or separation only
- Those that put in/put back or move some/all of a body part
- Those that alter the diameter/route of a tubular body part
- Those that always involve a device
- Those involving examination only
- Those that define other repairs
- Those that define other objectives

This is where things start to become a little complicated, says Lolita M. Jones, RHIA, CCS, an independent consultant in Fort Washington, MD. “One thing coders need to be sensitive to is that there are going to be terms they’re not used to seeing in their current documentation,” she says.

For example, root operations during which a surgeon removes some or all of a body part include the following:

- Extraction—Pulling or stripping out all or a portion of a body part by the use of force (e.g., dilation and curettage, vein stripping, or nail removal)
- Destruction—Physically eradicating all or a portion of a body part by use of force, energy, or a
Root operations < continued from p. 7

destructive agent (e.g., cautery of skin lesions, fulguration of rectal polyp, or fulguration of endometrium)

– Detachment—Cutting off all or a portion of an upper or lower extremity (e.g., below-knee amputations, above-elbow amputations, or disarticulation of the shoulder)

– Excision—Cutting out or off, without replacement, a portion of a body part (e.g., breast lumpectomy, partial nephrectomy, or liver biopsy)

– Resection—Cutting out or off, without replacement, all of a body part (e.g., total mastectomy, total nephrectomy, or total lobectomy of lung)

“In my opinion, this is the biggest change in healthcare since the implementation of DRGs back in the early ‘80s.”

—Shannon E. McCall, RHIA, CCS, CCS-P, CPC, CPC-I, CEMC, CCDS

this terminology [to ICD-10-PCS],” says Jones.

➤ Step four: Determine the fourth character, which denotes body part (the specific anatomical site where the procedure is performed).

➤ Step five: Determine the fifth character, which denotes the approach (the technique used to reach the site of the procedure). Approach options for procedures during which a surgeon removes some or all of a body part include the following:

– Through the skin (open, percutaneous, or percutaneous endoscopic)

– Through an orifice (via natural or artificial orifice, via natural or artificial orifice endoscopic, or via natural or artificial opening endoscopic with percutaneous endoscopic assistance)

– Externally

➤ Step six: Determine the sixth character, which denotes the device (any devices that remain after the procedure is completed). This does not include materials incidental to a procedure, such as clips and sutures. It also doesn’t include instruments that facilitate a procedure (e.g., instruments for visualization, such as a cystoscope).

➤ Step seven: Determine the seventh character, which denotes the qualifier (additional attributes of the procedure performed, when applicable). Examples include the type of transplant (allogenic, syngenic, or zooplastic) or a second site for a bypass.

Note that the specific options for root operation, body part, approach, device, and qualifier will vary depending on the applicable section of ICD-10-PCS.

Consider this example

For example, when a surgeon performs a percutaneous endoscopic resection of the sigmoid colon, the ICD-10-PCS alphabetic index leads coders to the following:

Resection
Colon
Sigmoid 0DTN

Next, refer to the ICD-10-PCS table to determine that the fifth character is “4” (denoting the approach), the sixth character is “Z” (denoting that no device was used), and the seventh character is “Z” (denoting no qualifier). Thus, the complete ICD-10-PCS code is 0DTN4ZZ.

When using the table, coders must remember to stay within the same row when assigning a complete code, says McCall. That’s because certain approaches, devices, and qualifiers are not permitted with certain body parts. For example, ICD-10-PCS code 02LR0CT is valid, but 02LR0CZ is not.

Test your knowledge

Code the following two case studies to test your knowledge of ICD-10-PCS coding for medical and surgical procedures:

➤ Case study 1:

Preoperative diagnosis—recurrent bladder tumors
Postoperative diagnosis—recurrent bladder tumors
Operation—Fulguration of recurrent bladder tumors

Findings—A 3-mm tumor on the right lateral wall; a 1-cm tumor just inside the left bladder neck

Procedure—The 67-year-old male patient underwent flexible cystoscopy. The above tumors, both papillary and clearly noninvasive, were identified. Pictures were taken, then they were cauterized. The bladder was then drained. The patient was taken to the recovery room.

**ICD-9-CM code:** 57.49, other transurethral excision or destruction of lesion or tissue of bladder

**ICD-10-PCS code:** 0T5B8ZZ (for the bladder tumor excision) and 0T5C8ZZ (for the bladder neck tumor excision)

**Rationale:** Refer to the ICD-10-PCS alphabetic index, which states the following:

*Fulguration—See destruction*
  *-Bladder 0T5B*
  *-Bladder neck 0T5C*

Then refer to the ICD-10-PCS table to complete the remainder of the code (i.e., body part, approach, device, and qualifier). Note that in this case, the approach is via a natural or artificial opening endoscopic. There is no device and no qualifier. In accordance with ICD-10-PCS coding guidelines, multiple procedures performed during the same operative session are coded if the same root operation is performed on different body parts as defined by distinct values of the body part character four.

➤ **Case study 2:**

Preoperative diagnosis—Prophylactic removal of left breast; status post right modified radical mastectomy for carcinoma of the right breast

Postoperative diagnosis—Same

Operation—Left total mastectomy with deep axillary node biopsy

Procedure—The patient was brought to the operating room (OR), carefully positioned, padded, and secured on the OR table. General endotracheal anesthesia was induced without complications or difficulty. The patient was carefully positioned. Venous compression stockings were placed and activated. The patient received preoperative antibiotics. The left breast was approached first. An elliptical incision was made. The extent of breast tissue was marked on the skin. **Superior, inferior, medial, and lateral flaps were raised.** The superior flap was taken to encompass the entire extent of the breast tissue and nearly up to the clavicle. The inferior flap was taken down to the origin of the rectus muscle, and the lateral flap was taken laterally out to the latissimus dorsi muscle. **Breast was dissected off and away from the anterior border of the latissimus dorsi muscle.**

The breast was then dissected off of the chest wall, **taking the pectoralis fascia along with specimen.** The specimen was divided from the lateral border of the pectoralis major and pectoralis minor muscles and an axillary sampling was performed as follows. Dissection was carried into the low axilla. Tissue was dissected down and away from the axillary vein. **The thoracodorsal and long thoracic nerves were carefully identified and preserved throughout the procedure.** The wound was irrigated and hemostasis assured. Two Jackson-Pratt drains were placed through separate stab wounds, secured with 2-0 Prolene. The skin was approximated with 3-0 Vicryl and running 3-0 Monocryl suture.

> continued on p. 10

**“I believe as time goes on, coders will be much more comfortable converting this terminology to ICD-10-PCS.”**

—Lolita M. Jones, RHIA, CCS

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**Upcoming event**

**February 18**—“HIM and The Joint Commission: Your Role in Survey Prep and Compliance,” featuring Jean S. Clark, RHIA, CSHA, director of accreditation at Roper St. Francis Healthcare in Charleston, SC.

To register or for more information about this audio conference, call 800/650-6787 or visit www.hcmarketplace.com and mention source code NEWSAD.
Then refer to the ICD-10-PCS code to complete the remainder of the code (i.e., body part, approach, device, and qualifier).

Regarding the mastectomy, the approach was open, and there was no device and no qualifier. Regarding the biopsy, the approach was open, there was no device, and the qualifier was diagnostic.

Editor’s note: The information in this article was originally presented during HCPro’s audio conference “ICD-10-PCS Surgery Coding: Understand and Apply Five Medical Surgical Root Operations.” For more information, visit www.hcmarketplace.com/prod-9043.

### Review FY 2011 ICD-10-PCS coding guidelines

It’s not too early to begin studying the ICD-10-PCS coding guidelines to prepare for implementation of the new coding system in 2013. Access the most recent version for FY 2011 at www.cms.gov/ICD10/Downloads/PCS2011guidelines.pdf. Note the following highlights:

1. When assigning a character to denote a body system, the term “upper” refers to portions of the body above the diaphragm. For example, partial codes 031–03W denote upper arteries. The term “below” refers to portions of the body below the diaphragm. For example, partial codes 041–04W denote lower arteries.

2. Procedures performed to provide access for a root operation are not reported separately. For example, don’t separately report a laparotomy performed to reach the colon for an open total colectomy.

3. Note that multiple procedures may require multiple ICD-10-PCS codes. Assign a code for each procedure when:
   - The same root operation is performed on different body parts (e.g., open resection of the right and left upper lung—report 0BTC0ZZ and 0BTG0ZZ, respectively)
   - The same root operation is performed at different body sites that are included in the same body part (e.g., open excision of the right deltid muscle and teres minor muscle, nondiagnostic—report 0KB50ZZ twice because both sites are considered part of the shoulder muscle)

   – Multiple root operations with distinct objectives are performed on the same body part (e.g., destruction of a lesion of the ascending colon and bypass of the ascending colon—report partial code 0D5 for the destruction and partial code 0D1 for the bypass)

   – A procedure is intended to be one approach, but is converted to another (e.g., a laparoscopy converted to an open cholecystectomy—report 0FJ44ZZ and 0FT40ZZ, respectively)

4. For bypass procedures, assign codes based on the body part bypassed “from” to the body part bypassed “to” (e.g., report 041L0ZL for a left open femoral-popliteal bypass with no device). The fourth character “L” denotes left femoral artery, and the seventh character “L” denotes popliteal artery.

5. Don’t separately report inspection of a body part to achieve the objective of the procedure. For example, don’t separately report a diagnostic esophagogastroduodenoscopy to destroy a gastric lesion.
During this audit-intensive climate and time of economic hardship, hospitals want to ensure that they are paid and don’t ultimately have to give that money back. In an effort to enhance compliance, hospitals want all the help and advice they can get regarding how to best operationalize various rules and regulations. However, not all advice is good advice, and coders need to think twice about the accuracy and timeliness of the information they receive.

Aside from the potential quality- and reimbursement-related implications of following bad—or even outdated—advice, why should coders care about this topic?

The Office of Inspector General, RACs, and the Payment Error Prevention Program require hospitals to return any money acquired inappropriately. This is regardless of whether a hospital made an honest mistake or engaged in fraudulent and dishonest behavior. Certainly, fraudulent billing also will result in fines over and above the payback. Therefore, coders must ensure that the advice they receive is accurate and compliant. Third-party auditors won’t care why you made an error—they will only care that you made it. And when there’s an error, your hospital should be prepared to give the money back.

Beware of outdated coding advice

Let’s discuss one example of how poor and outdated coding advice can lead coders down a wrong path and potentially into a third-party auditor’s trap.

The example pertains to a procedure called a percutaneous endoscopic gastrojejunostomy (PEGJ). One device involved in this procedure is a jejunal tube that is inserted through the PEG, often referred to as a JETPEG. During the mid to late 1990s, medical studies, physicians, and device manufacturers all referred to PEGJ as a procedure during which a surgeon used a patient’s existing PEG tube along with an endoscope for visualization and guidance to advance a thinner tube through the PEG and into the stomach. The surgeon then advanced the PEG tube past the pylorus and positioned it in the second or third portion of the duodenum.

The American Hospital Association’s (AHA) Coding Clinic addressed PEGJ in a Q&A in its 1st quarter 2001 publication. It said coders should report ICD-9-CM procedure code 44.39, other enterostomy, to denote the procedure. The AHA described the procedure perfectly in the citation. Code 44.39 grouped with other gastrojejunostomies to a major operating room (OR) procedure, thereby increasing reimbursement by thousands of dollars. Hospitals loved it.

No one ever realized that a PEGJ was actually an insertion of a jejunal feeding tube—a non-OR procedure—not a gastrojejunostomy. It wasn’t until 2009, when laboratory investigators began performing a PEGJ, that the true nature of the procedure was revealed. During this procedure, surgeons perform endoscopic visualization of the stomach, laparoscopic identification of proximal jejunum to bring the jejunum up toward the fundus of the stomach. Then, they perform endoscopic end-to-end anastomosis of the stomach and jejunum.

Because of this newfound knowledge, coders are now instructed to report ICD-9-CM procedure code 46.32, conversion of a gastrostomy to a jejunostomy with the use of an endoscope, instead of 44.39. Code 46.32 groups to a non-OR procedure, which is where it should have been all along.

The device manufacturing companies have since renamed the devices involved in the procedure to help
Bad coding advice  < continued from p. 11

prevent coding errors. Some examples of these devices are percutaneous endoscopic gastrostomy jejunostomy tubes (commonly known as PEG-J) and balloon-retained transgastric-jejunal feeding tube (commonly known as MIC-J).

Going forward, hospitals must report code 46.32 for a PEGJ. Any consultant who tells coders otherwise is just plain wrong.

Beware of incorrect manufacturer advice

A second example pertains to heart failure–related devices. These devices assist the left ventricle with its ability to supply enough cardiac output (i.e., adequate blood volume with adequate oxygen under adequate pressure) to the organs. Previously, placement of these devices involved open procedures. Then, surgeons began using implantable heart assist systems (ICD-9-CM procedure code 37.66), external partial pump support (ICD-9-CM procedure code 37.65), and the left ventricular assist device (ICD-9-CM procedure code 37.61).

Surgeons can implant these devices for use while patients await heart transplants. Patients also may use them temporarily while the heart recovers from some other insult such as a large myocardial infarction.

Today, surgeons also have the option of using a percutaneous device called the Impella®. The purpose of this device is to draw blood from a poorly functioning left ventricle and propel it into the aorta under enough pressure and with enough volume for the rest of the body’s organs until if and when the heart can recover. The device draws off and repressurizes 2.5 liters of blood per minute to aid a failing left ventricle.

The device’s manufacturer, Abiomed, says coders should report ICD-9-CM procedure code 37.68 (insertion of percutaneous external heart assist device) to denote insertion of this device. This code groups to MS-DRGs 216–221, cardiac valve and other major cardiothoracic procedures. This advice is supported by AHA’s Coding Clinic, 3rd quarter 2009, p. 12.

However, Abiomed also offers another Impella device with an output of 5 liters per minute, which provides considerably more blood delivery to the body’s organs. The manufacturer recommends that coders report ICD-9-CM procedure code 37.62, insertion of temporary non-implantable extracorporeal circulatory assist device, to denote insertion of this newer device. This code, which coders have rarely reported for Medicare patients over the past two years, groups to higher-weighted MS-DRG 215, other heart assist system implant.

A new code for the higher-yielding output device, which would group to MS-DRG 215, was suggested during the September 2009 ICD-9-CM Coordination and Maintenance Committee Meeting, but no new code was created. Instead, the committee decided that coders would report code 37.68 for all models and approaches of the Impella device.

However, Abiomed’s reimbursement guide continues to advise coders to report code 37.62 for the newer Impella device.

So what should coders do? Should they wait for the official rules to change before going out on a limb to follow manufacturer advice?

Coders who take the easy—and most profitable—way out could be putting their hospitals or providers at risk for fines potentially amounting to hundreds of thousands of dollars.

Editor’s note: For more information about coding Impella devices, refer to this month’s “Coding Q&A” insert.

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A physician documents in the history and physical that a patient has depression. The physician later documents that the patient also has anxiety. However, there is no explicit link between the anxiety and depression. Should we code these conditions separately, or may we code them as dysthymic disorder?

Report code 300.4 for dysthymic disorder. Locate this code by looking up “anxiety” in the ICD-9-CM index. Follow it to the subterm “depression,” which yields 300.4. Similarly, if you begin with the term “depression” and then locate the subterm “anxiety,” the index still leads to 300.4. The phrase “anxiety depression” also is located under the title for code 300.4. Thus, the physician does not need to link depression and anxiety.

A patient presents for a follow-up visit after undergoing surgery for insertion of a rod. The patient’s fracture is healing. Which code is more appropriate, V54.09 (other aftercare involving internal fixation device) or V54.16 (aftercare for healing traumatic fracture of lower leg)?

Based on the description of V54.09, I interpret it as the code for denoting scenarios in which the purpose of the encounter is to provide services directly related to the actual internal device (e.g., the rod).

Has Coding Clinic provided any guidance? The differences in the relative weights associated with the DRGs related to these codes are significant. What do you advise?

The only question Coding Clinic has published regarding this device appeared in 3rd quarter 2009. The advice pertains to Impella 2.5 heart assist device and instructs coders to report code 37.68. A proposal to create a new code (37.69) for Impella 5.0 was discussed during the September 2009 Coordination and Maintenance Committee Meeting, but no new code was created. At that time, CMS said coders should report code 37.68 for Impella 5.0 instead. CMS may consider creating a new code in the future. In the interim, continue to report code 37.68 for Impella 5.0.

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Based on the description of V54.09, I interpret it as the code for denoting scenarios in which the purpose of the encounter is to provide services directly related to the actual internal device (e.g., the rod).
Note that other more specific codes are for “removal” or “adjustment of a growth rod.” These codes suggest the physician does something to the device. Code V54.16 implies the patient is healing and is being seen for the healing fracture itself rather than for a specific adjustment to or removal of the rod or other inserted device.

If the patient was healing and the physician removed or adjusted the rod, both codes may be assigned if this information is documented in the record. ICD-9-CM Official Guidelines for Coding and Reporting, p. 72, lend the following support:

Aftercare codes should be used in conjunction with any other aftercare codes or other diagnosis codes to provide better detail on the specifics of an aftercare encounter visit, unless otherwise directed by the classification. The sequencing of multiple aftercare codes is discretionary.

Q What code should I report for a distortion product otoacoustic emissions (DPOAE) hearing test for a newborn? The only one I can find is ICD-9 procedure code 95.47 (hearing examination, not otherwise specified). Is this correct, or is another code more appropriate?

A Based on the ICD-9-CM Manual’s alphabetic index, 95.47 is the correct code for a DPOAE hearing test in a newborn. Neither Coding Clinic nor any other official guideline provides additional information. ICD-9-CM Volume 3 procedure codes are occasionally somewhat nondescript with respect to identifying certain procedures.

Shannon E. McCall, RHIA, CCS, CCS-P, CPC, CPC-I, CEMC, CCDS, director of HIM and coding at HCPro, Inc., in Danvers, MA, answered the previous two questions.

Q What certification requirements will coders need when ICD-10 takes effect?

A The Commission on Certification for Health Informatics and Information Management (CCHIIM) recently announced ICD-10 recertification requirements for individuals certified by the American Health Information Management Association (AHIMA).

AHIMA certified professionals need to participate in mandatory baseline educational experiences specific to ICD-10-CM/PCS, which will count toward the total CEU requirements for the purpose of recertification, the commission said in “ICD-10 CE Requirements for AHIMA Certified Professionals & FAQs.” Access this document at www.ahima.org/downloads/pdfs/certification/ICD10_CEU_FAQs.pdf.

CCHIIM lists the total number of ICD-10-CM/PCS CEUs required by AHIMA per credential as:
- CHPS–1 CEU
- CHDA–6 CEUs
- RHIT–6 CEUs
- RHIA–6 CEUs
- CCS-P–12 CEUs
- CCS–18 CEUs
- CCA–18 CEUs

Six CEUs equal one day of training. Those with more than one AHIMA credential need only report the highest number of CEUs obtained. Professionals have been able to begin earning ICD-10-CM/PCS–specific CEUs since January 1, 2011; anyone who previously completed AHIMA’s Academy for ICD-10 may use those CEUs to fulfill the ICD-10-CM/PCS continuing education requirement.