Editor’s note: The following article is provided as a supplement to the July 2011 CDI Journal. Note that this special supplement is not intended to replace or serve as a substitute to official guidance published in Coding Clinic. CDI specialists are strongly encouraged to obtain their own subscription to Coding Clinic for ICD-9-CM and to read and apply its advice in concert with their own coding and compliance departments. Learn more about Coding Clinic for ICD-9-CM at www.ahacentraloffice.com.

Greetings CDI specialists, coders, coding auditors/educators, and physician advisors. It’s time to review the AHA Coding Clinic for ICD-9-CM, Second Quarter 2011, as we partner with physicians to clarify inconsistent, incomplete, imprecise, conflicting, and illegible clinical documentation in the medical record and to apply ICD-9-CM coding conventions and guidelines in a compliant manner.

This was a light issue for CDI specialists, as much of the published guidance pertained to straightforward issues. Nevertheless, there were a couple of important entries on acute renal failure (ARF) in the setting of end-stage renal disease (ESRD), the clinical significance regarding lysis of adhesions, and others entries for which physician education and compliant query updates may be needed.

Let’s take a look at what the AHA Central Office on ICD-9-CM had to say.

Principal procedure (p. 3)
A reader inquired whether the concept of the principal procedure was important in code assignment.

CDI specialists should know that MS-DRGs are based on classifications and terminology consistent with the ICD-9-CM and the Uniform Hospital Discharge Data Set (UHDDS), as recommended to the Secretary of the Department of Health and Human Services (HHS) by the National Committee on Vital and Health Statistics (Uniform Hospital Discharge Data: Minimum Data Set, National Center for Health Statistics, April 1980), revised in 1984 by the Health Information Policy Council of the HHS, and approved for use by the Secretary of HHS for use starting January 1986.

For those with access, the 1985 Federal Register (online access is only available to Federal Register publications after 1993), may be found at www.ncbi.nlm.nih.gov/pubmed/10272121.
The following UHDDS definitions are requirements of the ICD-9-CM coding system and have been used as a standard for the development of DRGs:

- Diagnoses are defined to include all conditions that affect the current hospital stay. Those that do not affect the current hospital stay are added only if required by hospital policy.
- The principal diagnosis is defined as the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.
- Other diagnoses (also called secondary diagnoses or additional diagnoses) are defined as all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received or the length of stay or both. Diagnoses that relate to an earlier episode of care that have no bearing on the current hospital stay are excluded.
- All procedures performed will be reported. This includes those that are surgical in nature, carry a procedural risk, carry an anesthetic risk, or require specialized training.

In this entry, Coding Clinic emphasizes that the principal procedure is defined as a procedure performed for definitive treatment, rather than diagnostic or exploratory purposes, and/or is a procedure performed to treat a complication. This should not be a surprise to those familiar with coding fundamentals; however, since neither the ICD-9-CM Official Guidelines for Coding and Reporting nor the ICD-10-PCS addresses the definition of principal procedure, I am glad that Coding Clinic covered this subject.

What this advice does not state is that CMS believes the principal procedure must be related to the principal diagnosis, evidenced by the following statement in CMS’ report to Congress on Recovery Audit Contractors released in this fall and available at http://tinyurl.com/6cezef9. On p. 20, this report states:

*The principal diagnosis and principal procedure codes for an inpatient claim should be related. Errors occur when providers bill an incorrect principal and/or secondary diagnosis that results in an incorrect Medicare Severity Diagnosis-Related Group assignment.*

Coding and CDI staff working in the hospital setting must pay special attention to principal diagnosis and principal procedure assignment for the following reasons:

- If the principal diagnosis is not related to any designated principal or secondary procedures, many DRG algorithms, such as MS-DRGs and 3M’s APR-DRGs, group to the category “Procedure not related to Principal Diagnosis,” which, more often than not, has a higher relative weight than customarily attained for the procedure. Of course, these are more likely to be audited, thus they should be assigned with care.
If a patient has two significant reasons for inpatient admission and two significant surgical procedures are performed during a hospital admission, Medicare’s surgical hierarchy may result in a surprising DRG assignment based on which diagnosis is assigned as the principal diagnosis.

This is best explained by an example. Consider a patient with known aortic stenosis who is being evaluated for an aortic valve replacement. Due to severe hyperkalemia found on the admitting laboratory, the patient was admitted to lower the serum potassium level. Rather than discharging the patient, the patient undergoes an aortic valve replacement and removal of a substernal goiter. See what happens when 276.7, Hyperpotassemia, or 424.1, Aortic valve disorder, is sequenced as the principal diagnosis in the setting of procedure codes 35.22, Open and other replacement of the aortic valve, and 06.52, Complete substernal thyroidectomy.

I firmly believe that CDI specialists should learn how to use an encoder, especially in their preparation for ICD-10. If your facility hasn’t granted CDI staff access to this important tool and resource, ask for it, learn how to use it, and do this in conjunction and cooperation with your HIM department coding staff.

Conversion disorder with pseudoseizures (p. 5)

In this entry, a patient is found after a psychiatric evaluation with pseudoseizures in the setting of post-traumatic stress disorder and attention deficit hyperactivity disorder and after a neurological examination whereby a seizure disorder was ruled out. Coding Clinic advised to assign code 300.11, Conversion disorder, as the principal diagnosis, with 780.39, Other convulsions, added as a secondary diagnosis.

This advice may be controversial, given how the term “pseudoseizure” is listed in the ICD-9-CM Alphabetic Index of Diseases.

Pseudoseizure  780.39
  • non-psychiatric  780.39
  • psychiatric  300.11

Note that psychiatric pseudoseizure does not have an additional code for 780.39. Other convulsions, listed in the Index to Diseases. It appears to me that this pseudoseizure was psychiatric in nature, requiring only code 300.11 to be assigned.

This entry also raises the issue of whether symptom codes (which, in this case, is 780.39, Other convulsions) routinely associated with their underlying condition should be coded. The ICD-9-CM Official Guidelines for Coding and Reporting states:
Signs and symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the classification.

One may argue that a convulsion or seizure is integral to a psychiatric pseudo seizure, given how it is listed in the Alphabetic Index to Diseases.

Why does this matter? While this advice does not affect MS-DRGs or Medicare’s inpatient psychiatry prospective payment system, it does affect APR-DRGs. Note the following scenarios:

- Scenario 1: Principal diagnosis of psychiatric pseudoseizure alone; APR-DRG 880 – Acute Anxiety and Delirium; SOI – 1; relative weight of 0.4173
- Scenario 2: Principal diagnosis of psychiatric pseudoseizure (300.11) with a secondary diagnosis of seizure, 780.39; APR-DRG 880 – Acute Anxiety and Delirium; SOI – 2; relative weight of 0.5016

Consider this advice in relation to ICD-9-CM conventions and the ICD-9-CM Official Guidelines for Coding and Reporting when submitting these codes for potential inpatient reimbursement.

Medical marijuana (p. 7)

This entry states that when marijuana is prescribed by a physician for patient use, code 305.2x, Nondependent abuse of drugs, cannabis abuse, is NOT assigned. Instead, V58.69 (Long-term current use of other medications) should be assigned, given that when marijuana is prescribed by a physician in accordance with state law and taken as directed, it is not considered abuse.

Should an adverse effect occur due to overdosage or because prescribed marijuana was inappropriately administered, an appropriate poisoning code should be assigned. Consider Coding Clinic, 5th Issue 1994, p. 9, for further clarification.

Excisional debridement (p. 11)

In this scenario, a patient is diagnosed with necrotizing soft tissue abscess/infection of the buttock, which was surgically addressed. The provider’s documentation included:

- A title of an excisional debridement of skin and subcutaneous tissue
- Description in the operative note of connection of the abscesses with incision, extensive excision of wound, and breaking and unroofing of smaller abscess cavities

Coding Clinic tells us that this documentation is sufficient to assign procedure code 86.22, Excisional debridement, and that the incisions of the wound would be considered integral to the excisional debridement. This is a
reminder that physicians must say the words “excisional debridement” and reasonably describe this in their operative reports for it to be coded, thus the physician documentation is key.

Mediastinum tumor vs. goiter (p. 12)

In this entry, a patient has a preoperative diagnosis of mediastinum tumor as described on the operative note; the nature of the tumor’s pathology was not known at the time of surgery. Later, a pathology report indicated that the tumor’s pathology was a mediastinum goiter. The question was which of the following procedure codes was to be assigned:

- 34.3, Excision or destruction of lesion or tissue of mediastinum
- 06.51, Partial substernal thyroidectomy

To my surprise, Coding Clinic recommended code 34.3 (Excision or destruction of lesion or tissue of mediastinum) to report the procedure. Assignment of the procedure code was based on the surgery performed as described in the operative report (which we do not have access to), not on the findings of the pathology report, Coding Clinic notes. Given that the provider only documented the excision of a tumor in the operative report, not a removal of thyroid tissue, Coding Clinic opined that 34.3 should be the correct code. (See “Figure 1.1: DRG options for mediastinum tumor vs. goiter” for FY 2012 DRG options.)

A couple of lessons to learn from this:

- Given that the information on the pathology report influenced the DRG, if the provider has not brought this information forward as to determine the principal diagnosis, a physician query is absolutely mandatory.
- Within Coding Clinic there is the appearance that the description of the nature of the operative tissue as described in the operative report may take precedence over what is in the pathology report. Additional clarification of the principle from Coding Clinic is needed.

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**Figure 1.1: DRG options for mediastinum tumor vs. goiter**

<table>
<thead>
<tr>
<th>Scenario</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>PDx</td>
<td>240.9 – Goiter</td>
<td>786.6 – Swelling/mass/lump in chest</td>
<td>240.9 – Goiter</td>
<td>786.6 – Swelling/mass/lump in chest</td>
</tr>
<tr>
<td>Procedure</td>
<td>34.3 – Excision or destruction of lesion or tissue of mediastinum</td>
<td>34.3 – Excision or destruction of lesion or tissue of mediastinum</td>
<td>06.51 – Partial substernal thyroidectomy</td>
<td>06.51 – Partial substernal thyroidectomy</td>
</tr>
<tr>
<td>MS-DRG (FY 2012)</td>
<td>630 – Other endocrine, nutritional, and metabolic OR procedure w/o CC/MCC</td>
<td>165 – Major chest procedure w/o CC/MCC</td>
<td>627 – Thyroid, parathyroid, and thyroglossal procedure w/o CC/MCC</td>
<td>983 – Extensive OR procedure unrelated to principal diagnosis w/o CC/MCC</td>
</tr>
<tr>
<td>Relative weight</td>
<td>1.3128</td>
<td>1.7854</td>
<td>0.8008</td>
<td>1.7404</td>
</tr>
</tbody>
</table>

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Whether amendments of the operative report in light of the pathology report are warranted is an interesting question that may need to be addressed by a facility’s compliance department or through another question to Coding Clinic, given the difference in relative weights in scenario 1 and 3.

ARF and ESRD (p. 15)
In this entry, Coding Clinic states that ARF and ESRD can occur during the same encounter in the presence of trauma or some other insult. Thus, if a provider documents both ARF and ESRD, code each condition separately.

This topic has been discussed in past issues but bears repeating and sharing with your medical staff. Many nephrologists label patients with chronic kidney disease as having ESRD when they require chronic dialysis or until they recover renal function after a renal transplant, upon which the term “ESRD” is converted back to “chronic kidney disease.” This contrasts to official definitions of ESRD from CMS and the Kidney Disease: Improving Global Outcomes (KDIGO) group:

- **CMS:** “End-Stage Renal Disease (ESRD) is a kidney impairment that is irreversible and permanent and requires either a regular course of dialysis or kidney transplantation to maintain life.” (www.cms.gov/CFCsAndCoPs/downloads/ESRDfinalrule0415.pdf)

- **KDIGO:** “End-stage renal disease (ESRD) is an administrative term in the United States, based on the conditions for payment for health care by the Medicare ESRD Program, specifically the level of GFR and the occurrence of signs and symptoms of kidney failure necessitating initiation of treatment by replacement therapy. ESRD includes patients treated by dialysis or transplantation, irrespective of the level of GFR.” (www.kidney.org/professionals/kdoqi/guidelines_ckd/p4_class_g1.htm)

Note that nowhere in these definitions is any indication that the term “ESRD” should not be used in a patient with a functioning kidney transplant. This is why ARF can occur in a patient with ESRD, given that a functioning kidney transplant required to maintain life (see CMS definition) or serving as renal replacement therapy (see KDIGO definition) can acutely fail.

The challenge for our coding staff and CDI specialists in interpreting and implementing this advice is the prevailing definition of ESRD embraced by their facility’s nephrology staff. Review these references and discuss them with the nephrology team as the facility considers this advice.

Lysis of adhesions: Clarification (p. 17)
Coding Clinic concludes this issue with three clarifications on the proper reporting of lysis of adhesions. Prevailing concepts include:
Unless the surgeon documents the clinical significance of the adhesions in the body of the operative report, neither the adhesions nor their lysis can be coded. Furthermore, the mere presence of adhesions and their lysis does not mean that they should be coded.

Surgeons must use words such as “numerous adhesions requiring a long time to lyse,” “extensive adhesions involving tedious lysis,” “extensive lysis,” or similar language to code this condition and procedure.

This entry also states to query the provider if you are unclear on the clinical significance of the lysis and is consistent with prior advice on this subject.

As you can see, review of the quarterly AHA Coding Clinic adds great value to our CDI work. I encourage every concurrent reviewer, coder, physician advisor, compliance officer, and invested individual to read this advice for yourself and submit your own questions to Coding Clinic when you encounter challenging issues. Coding Clinic may be reached at:

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Phone: 312/893-6800
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Requests for coding advice should be faxed to 312/278-0838.

You may also wish to listen to Coding Clinic perspectives regarding their advice during their regularly scheduled audio conferences. Learn more by visiting www.ahacentraloffice.com.

Editor’s note: Kennedy is a managing director for FTI Consulting’s Clinical Documentation and Coding Integrity service offerings and is based in Atlanta and Nashville. His team supports providers and facilities in their quest for accuracy in ICD-9 and CPT code assignment and in their preparation for ICD-10. He may be reached at james.kennedy@fticonsulting.com or 615/479-7021.