It’s time to begin thinking about resolutions for 2013

The new year is right around the corner, and we’ll be another year closer to the ICD-10-CM/PCS implementation date of October 1, 2014.

What goals will you set for yourself in the coming year to ensure that you can remain viable in today’s marketplace?

Briefings on Coding Compliance Strategies asked several coding and HIM professionals what tasks should be on every inpatient coder’s to-do list in 2013. This is what they said.

#1: Undergo a coder assessment to gauge your ICD-10 readiness, says Gloryanne Bryant, RHIA, CCS, CDIP, CCDS, an HIM consultant in Fremont, Calif., with more than 30 years of experience. Ideally, this assessment should occur as soon as possible and definitely during the first quarter of 2013 to allow maximum training time. If necessary, arrange refresher education in anatomy, physiology, medical terminology, pharmacology, and pathophysiology throughout 2013.

#2: Take a one-day ICD-10 course or listen to introductory audio conferences that address the topic, says Rose T. Dunn, MBA, CPA, RHIA, FACHE, chief operating officer at First Class Solutions, Inc., in St. Louis. This will lay the foundation for the next year and a half of preparation, she says. In-depth ICD-10 training can occur thereafter.

#3: Perform a side-by-side comparison of ICD-9-CM and ICD-10-CM coding guidelines, says Dunn. Use a highlighter to identify any differences. Also, read the ICD-10-PCS coding guidelines to become familiar with the coding logic and character descriptions, she says.

#4: Assist with an ICD-10 documentation assessment to identify new query opportunities and opportunities to revise existing queries, says Bryant.

#5: Inquire about dual coding and computer-assisted coding (CAC). Dual coding can be extremely helpful, but organizations must determine whether their current systems can accommodate both ICD-9-CM and ICD-10-CM/PCS codes simultaneously, says Bryant. CAC may also be beneficial by offsetting any anticipated decrease in productivity. Organizations that plan to implement CAC should strive to do so by the first quarter of 2014. In the meantime, coders should take the initiative to learn more about the technology and be prepared to work with it, she says.

#6: Assist with specialty-specific ICD-10 training for physicians, says Jean Stone, RHIT, CCS, CDIP, manager of clinical documentation integrity program/HIMS at...
Lucile Packard Children’s Hospital at Stanford in Palo Alto, Calif. Reiterate why coding is important with respect to patient care, and highlight differences between ICD-9-CM and ICD-10-CM/PCS that matter most to each physician’s specialty, she says.

#7: Dig deeply into current documentation. Flag discrepancies, uncodeable diagnoses, or vague references to abnormalities without documentation of explicit diagnoses, and query for more specific information, says Stone.

#8: Clarify your role in your organization’s CDI initiative, says Cindy L. Seel, MS, RHIA, director of education and training at HRS in Baltimore. If your hospital has a well-developed CDI program, what will your role in the query process be when ICD-10 becomes effective? How will you work together with CDI staff?

#9: Study the seven surgical approaches in ICD-10-PCS, and identify examples of each approach, says Dunn.

#10: Memorize the definitions of the 31 ICD-10-PCS root operations, says Dunn. Identify procedures that map to each root operation, she says. Quiz yourself regularly to keep your knowledge current.

#11: Read articles about ICD-10 published by HCPro, AHIMA, and others regularly, says Dunn.

#12: Practice coding one case weekly with your encoder (if it has ICD-10 capability) or ICD-10 coding manuals, says Dunn.

#13: Reward yourself to validate and recognize your hard work and accomplishments year-round.

**Goals for 2013?**

Share your goals for 2013 with Contributing Editor Lisa Eramo at leramo@hotmail.com. •

Editor’s note: Ready to dive into ICD-10? HCPro’s ICD-10 Training Toolkit can help. Toolkit components include:

➤ The Coder’s Guide to ICD-10: This 100-page training guide includes detailed information about the new code sets for outpatient and inpatient coders that will introduce the new system, reduce fears, and help you understand the differences between ICD-10 and ICD-9-CM.

➤ ICD-10 Competency Assessment for Coders: Anatomy and Physiology

➤ ICD-10 Competency Assessment for Coders: ICD-10-CM and ICD-10-PCS

➤ ICD-10 Flashcards: These flashcards will strengthen your understanding of the new code set and root operations.

➤ ICD-10 Mail for Physicians: This CD-ROM includes 52 email messages for a year of information tailored to physician needs with an emphasis on documentation guidance.

➤ ICD-10 Mail for Coders: This CD-ROM includes 52 email messages with tips and quiz questions.

To learn more, visit www.hcmarketplace.com/ prod-9730/ICD10-Training-Toolkit.html.
Powerful antidotes to cure ICD-10-PCS fears

ICD-10-PCS may prove to be far more challenging for inpatient coders than ICD-10-CM. For some, it may even be downright scary.

Why?

ICD-9-CM procedure codes are generally very nonspecific, which makes PCS incredibly daunting, says Charlotte Lane, RHIA, CCS, an independent consultant and AHIMA-approved ICD-10-CM/PCS trainer and ambassador in Fredericksburg, Texas.

Melanie Endicott, MBA/HCM, RHIA, CDIP, CCS, CCS-P, director of HIM solutions at AHIMA and an AHIMA-approved ICD-10-CM/PCS trainer in Newport, Wash., agrees. “The structure and specificity are so different from what we’re currently using. We haven’t had to look for this level of detail,” she says.

However, experts say there’s no need to fear ICD-10-PCS. Consider the following antidotes to boost your confidence and banish your fears.

Decrease in productivity

The harsh reality is that productivity is expected to decrease initially after October 1, 2014. It may never return to pre-ICD-10-PCS levels, says Becky Buegel, RHIA, CHP, CHC, healthcare administration program director at Brookline College and an AHIMA-approved ICD-10-CM/PCS trainer in Phoenix. This creates anxiety for many coders.

Antidote: Knowledge is power. Offset any anticipated decline in productivity by learning basic ICD-10-PCS concepts and taking refresher courses in anatomy and physiology (A&P). Then use this information to identify documentation gaps, says Endicott. For example, orthopedic documentation may not affect coder productivity at all because physicians already document the necessary details in that area. However, cardiovascular documentation may require physician education and coder training, she says.

Make it a habit to review the entire operative report—not only the title—when coding procedures, says Lane. Identify elements in each operative report that will be necessary for coding in ICD-10-PCS, even if those elements don’t affect code assignment today. This can greatly decrease the productivity slowdown when ICD-10-PCS takes effect, she says.

Greater reliance on anatomy and physiology

ICD-10-PCS requires greater anatomical specificity, which many coders fear will not appear in the record. Physicians may need to improve their documentation. However, coders must also know how the anatomical specificity that physicians document affects ICD-10-PCS code assignment.

Antidote: Begin with an A&P assessment. This can help identify areas of strength and weakness, and it can also serve as the foundation for learning ICD-10-PCS.

Reviewing the branches of veins and arteries can facilitate coding vascular procedures in ICD-10-PCS, says Endicott. For example, when a physician documents performing a percutaneous endoscopic repair of the left anterior humeral circumflex artery, coders should report ICD-10-PCS code 03Q64ZZ. The reason is that the anterior humeral circumflex artery is part of the axillary artery branch, as denoted by the 4th character in the code.

Distinguish between body parts and body systems, says Buegel. A body system refers to the general location in which a procedure occurs. A body part identifies the specific anatomic site at which a procedure is performed. Some organs and anatomic sites are located in more than...
one body part. For example, the colon (large intestine) consists of the ascending colon, descending colon, and transverse colon—each of which is considered a separate body part in ICD-10-PCS.

A&P training for coders is important, but access to respected medical references, journals, and other resources is equally important, says Buegel. Coders can’t be expected to memorize all aspects of human anatomy, she says.

Note that Appendix C in the ICD-10-PCS Manual also provides a body part key that coders can reference when mapping anatomical terms to PCS descriptions.

Root operations

Root operations create anxiety for coders because some of the terms are completely new (e.g., extirpation) and because they may not match physician documentation precisely.

Antidote: “We have to rearrange how we would think about information and how we would approach looking up the code,” says Lane. When reporting root operations, coders should always ask a central question, she says: What is the purpose of the procedure? What will it accomplish?

For example, a physician documents removing the left upper lobe of the lung. Coders may be tempted to report a removal. However, ICD-10-PCS classifies this term as “taking out or off a device” (e.g., removal of an endotracheal tube). Instead, coders should report a resection (i.e., “cutting out, without replacement, all of a body part”). The left upper lobe is considered a body part.

Similarly, the insertion of an impeller pump heart-assist device is not an insertion but rather an extracorporeal performance. “These devices perform a function. They take over the function and pumping of the heart,” says Lane. Therefore, coders should report ICD-10-PCS code 5A0221D.

Appendix A in the ICD-10-PCS Manual is worthy of review because it includes definitions for all root operations along with explanations and examples. “Coders should drill themselves now on this information. These definitions are very specific,” says Lane.

However, coders must also become comfortable making certain interpretations, says Endicott. “What we don’t want coders to do is send the record back to the physician and say, ‘You said removal, and you should have said resection. Can you change this?’” she says. “We are supposed to be able to interpret what was done based on the clinical documentation.”

Discussing certain procedures with physicians or simply watching a video of the procedure may help identify the correct root operation, says Endicott.

Documentation insufficiency

In addition to a lack of anatomical specificity, many coders fear that documentation generally won’t be up to par. Insufficient documentation could prevent them from assigning correct PCS codes—or from assigning any PCS code at all.

Antidote: Although ICD-10-PCS requires additional specificity, much of the information that coders need to assign ICD-10-PCS codes is already present in the record, says Endicott. “When you look at the codes and what physicians already need to document for CPT® coding, oftentimes the documentation is there,” she says. “Coders just aren’t used to looking for it.”

Lane agrees. She hopes that additional guidance pertaining to acceptable source documentation for code assignment will be forthcoming. For example, if operative reports don’t specify the contrast medium used during a ventriculogram—a detail necessary for assigning an ICD-10-PCS imaging code—coders ideally should be able to obtain this information from the computerized cardiac catheterization report.

Lack of eponyms

Many procedures are named after the individual who created the procedure or who improved upon the procedure’s surgical technique. The ICD-9-CM index includes entries based on these eponyms, making it easy for coders to identify them based on documentation. However, ICD-10-PCS doesn’t include any eponyms. This reinforces the importance of root operations and of having a general understanding of procedures, says Lane.
For example, the ICD-10-PCS index doesn’t include an entry for a Whipple procedure, which is named for the American surgeon Allen Whipple, MD. During a Whipple procedure—also known as a pancreaticoduodenectomy—a surgeon removes the head of the pancreas, the duodenum, a portion of the common bile duct, the gallbladder, and sometimes part of the stomach. Surgeons then reconnect the remaining intestine, bile duct, and pancreas.

Coders currently report ICD-9-CM procedure code 52.7 to denote a Whipple procedure. This code doesn’t consider any modifications to the standard procedure because it doesn’t denote each individual body part removed. However, in ICD-10-PCS, coders must report a separate code for each body part that the surgeon removes, which typically yields eight different codes. These codes likely will include different body parts and multiple root operations (e.g., excision, resection, or bypass), depending on the patient’s specific circumstances and needs.

ICD-10-PCS, therefore, can better capture modified Whipple procedures, says Lane. For example, if a patient had previously undergone a cholecystectomy (removal of the gallbladder), this code would be absent from any subsequent Whipple procedure the patient undergoes.

**Antidote:** Reviewing A&P can benefit coders. The Internet, medical dictionaries, and other medical references will also be important, says Buegel.

**Other ways to dispel fears**

Still spooked by ICD-10-PCS? Consider these tips:

➤ **Review the 2013 ICD-10-PCS Official Guidelines for Coding and Reporting.** The guidelines (available at www.cms.gov/Medicare/Coding/ICD10/Downloads/pcs_2013_guidelines.pdf) are extremely detailed and useful for coders to review, says Lane. After reviewing the guidelines, coders can think about how certain procedures might be coded in ICD-10-PCS as they continue to code in ICD-9-CM.

For example, review ICD-10-PCS guidelines pertaining to bypass procedures. Generally, bypass procedures are coded by identifying the body part bypassed *from* (i.e., the 4th character in the PCS code) and the body part bypassed *to* (i.e., the qualifier). For example, in a bypass from stomach to jejunum, the stomach is the body part and the jejunum is the qualifier.

Coronary artery bypass procedures are the exception, says Lane. These procedures are classified by the distinct number of sites treated rather than the number of coronary arteries or anatomic name of a coronary artery. This means that rather than identifying the body part bypassed from, the body part in an ICD-10-PCS code for a coronary artery bypass identifies the number of coronary artery sites bypassed to. The qualifier specifies the vessel bypassed from. For example, a surgeon performs an aorto coronary artery bypass of one site on the left anterior descending coronary artery and one site on the obtuse marginal coronary artery. ICD-10-PCS classifies this as two coronary artery sites, and the qualifier specifies the aorta as the body part bypassed from.

➤ **Read AHA Coding Clinic for ICD-10-CM/PCS when it’s published.** Endicott hopes that Coding Clinic will resolve some of the grey areas in ICD-10-PCS and calm anxiety around code assignment uncertainty. Once published, it will also better enable coders to practice coding current cases in ICD-10-PCS.

➤ **Determine who will submit ICD-10-PCS queries.** Will this become coders’ responsibilities, or will CDI specialists assume this role? CDI programs have traditionally focused on diagnoses—not procedures, says Lane.

➤ **Consider peer reviews.** “In the beginning, you might need to have 100% peer review on every PCS code,” says Endicott. “It may seem arduous, but if you want to have accurate data, you may need to do this to ensure that the inpatient coders in your department are coding correctly and consistently.”

Questions? Comments? Ideas?

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Major joint replacement and medical necessity

Have you read MLN Matters® article SE1236 lately?
Coders may not be familiar with this article about documenting medical necessity for major joint replacements because it’s intended primarily for physicians, according to CMS.

It isn’t surprising that physicians are CMS’ intended audience for SE1236, says Glenn Krauss, BBA, RHIA, CCS, CCS-P, CPUR, C-CDI, CCDS, an independent HIM consultant in Madison, Wis., and author of HCPro’s Documentation Improvement Guide to Physician E/M. “Who controls the documentation? The doctor does. The doctor decides whether the patient needs surgery. Hospitals are at the mercy of the doctors,” he says.

However, article SE1236 also applies to hospitals and coders, says Krauss. “It’s certainly of interest to hospitals, even more so because there’s more at risk,” he says.

Article SE1236 states:

Multiple auditing entities, including the Recovery Audit Contractors, Comprehensive Error Rate Testing [CERT] Contractors, and Medicare Administrative Contractors [MACs] have demonstrated very high paid claim error rates among both hospital and professional claims associated with major joint replacement surgery.

“It’s right down to the first line of review,” says Krauss. “The carriers, FIs, and MACs are taking direction from the [Recovery Auditors] and Medicare.”

Coders and medical necessity

Article SE1236 reminds physicians to thoroughly document medical necessity for joint replacement surgery. This documentation is important with respect to patient care and avoiding denials, says Krauss.

CMS states in SE1236 that joint replacement surgery is reserved for patients whose symptoms have not responded to other treatments; documentation should support the determination that major joint replacement surgery was reasonable and necessary. Such documentation includes a chief complaint, detailed history of present illness, physical examination based on signs and symptoms, any tests or diagnostic workups performed, final diagnosis, plan of care, and most importantly, ongoing clinical judgment. Progress notes that include conclusive statements without any supporting rationale are unacceptable, according to CMS.

“Osteoarthritis of the hip used to be sufficient, but the tides have turned, and physicians haven’t changed their documentation patterns,” says Krauss.

Documenting failed conservative therapy is also insufficient, and it should raise a red flag for coders. “Instead, [documentation] should be an accurate depiction of physicians’ medical decision-making. How did the doctor devise his or her plan of care? What did he or she consider when diagnosing the patient and recommending a course of treatment?” says Krauss.


Krauss offers this example of proper documentation:

Mrs. Jones is a 75-year-old patient well known to me who has been coming to me for years with progressive osteoarthritis. She is not able to walk without a walker. She lives in a three-story house and is unable to get to the bathroom on the second floor. We tried whirlpool therapy, a course of physical therapy. She improved slightly, but she still has ongoing and sometimes severe pain that prevents her from walking even with the use of her walker. Her range of motion has decreased 50% over the last year. We tried pain injections for a six-month course. These were not successful. A decision was made to perform a hip replacement in order to increase her activities of daily living and reduce the risk of decubitus ulcer and possible falls, particularly since she lives alone and does not have good social support.

Preparing for ICD-10-PCS

Physicians must thoroughly document medical necessity,
and they will need to start documenting information necessary for ICD-10-PCS, says Lynn Marlow, BS, RHIT, CCS, auditing and education consultant at TrustHCS in Springfield, Mo. For example, ICD-10-PCS requires laterality for both hip and knee replacements. For hip replacements involving synthetic substitutes, ICD-10-PCS also requires the type of bearing surface used (i.e., metal on polyethylene, metal on metal, ceramic on ceramic, or ceramic on polyethylene). This information is reported as the 7th character in the PCS code. Also note that the 6th character denotes the device (i.e., the replacement). ICD-10-PCS considers the replacement a device because it remains in the body after the procedure is completed.

Marlow says physicians don’t often document the type of bearing surface used. However, coders and CDI specialists can advocate now for this information.

**Article SE1236 and other resources**

As coders review documentation of major joint replacements to ensure compliant coding, they should also be on the lookout for medical necessity as well as details necessary for ICD-10-PCS. Article SE1236 provides actual examples of documentation that meet medical necessity for joint replacement surgery. Although the examples don’t describe all of the necessary documentation required for this type of surgery, coders and CDI specialists can use the information for educational purposes.

The MLN Matters article also provides this example of documentation that may result in a denied claim:

*Mrs. Smith is a female, age 70, with chronic right knee pain. She states she is unable to walk without pain, and pain meds do not work. Therefore, she needs a total right knee replacement.*

Coders should use article SE1236 as a road map for CDI, says Krauss. Retrieve and review 10 records that include documentation of major joint replacement surgeries (i.e., hip or knee). How does documentation in those records compare with the examples in the article? Address any deficiencies directly with physicians, he says.

Case managers should automatically review hospital and office note records when major joint replacement surgeries are scheduled to ensure that the records include a detailed history of present illness, relevant physician office notes, radiology workups, and more, he says.

Fundamentally, article SE1236 should serve as a reminder to coders that if they observe patterns of insufficient documentation—particularly documentation that jeopardizes medical necessity—they should bring it to the attention of a case manager or coding manager, says Krauss. Not doing so indirectly contributes to denials. All allied health professionals, including coders, have a duty and vested interest in avoiding costly retrospective denials from Medicare contractors, he says.

Coders are in an ideal position to identify documentation insufficiencies because they’re already reviewing records in their entirety to code hospital stays, says Krauss. Coders shouldn’t simply code conditions or procedures that they know will ultimately be denied. “There’s no point in getting something billed if you’re only going to get the money taken back,” he says.

Use article SE1236 to educate physicians directly, says Marlow. “It’s definitely something that would be of interest to them,” she says. For example, one of Marlow’s hospital clients created “Scrub Sink News,” a compilation of quick tips and educational information for physicians posted above scrub sinks in operating rooms and regularly updated by coders and CDI staff. It became a convenient, concise, nonintrusive way to educate physicians, says Marlow.

Also consider the following resources with respect to physician education:

➤ *Joint Replacement Documentation Notice*, published by TrailBlazer on March 14. This document (available at [http://tinyurl.com/9qhl2nj](http://tinyurl.com/9qhl2nj)) includes examples of end-stage joint disease documentation that may help support payment for knee or hip joint replacement–related hospital care.

Are coders receiving questionable advice?

by Robert S. Gold, MD

Official coding guidance is a crucial part of the IPPS. This guidance, which includes the ICD tabular classification and index as well as the ICD-9-CM Official Guidelines for Coding and Reporting, AHA Coding Clinic®, and a variety of other educational tools published by coding experts, is intended to ensure that the payment system functions correctly.

The target audience for each of these publications has always been coders and HIM professionals. Why? ICD codes are directly tied to reimbursement. The World Health Organization doesn’t use ICD codes for this purpose. Thus, its involvement in any guidance related to the assignment of ICD codes has been minimal.

Unfortunately, coding guidance sometimes includes inappropriate definitions and rules. Recovery Auditors are taking advantage of these loopholes, and now hospitals are paying the price, literally.

Primary cardiomyopathy

Various issues of Coding Clinic include references to the assignment of ICD-9-CM code 425.4 (other primary cardiomyopathies). However, each reference ignores the term primary—an essential modifier in the definition of the code. Two references direct coders to report code 425.4 for congestive cardiomyopathy even when the physician doesn’t document the term primary. Two additional references direct coders to report code 425.4 for dilated cardiomyopathy even when the physician doesn’t document the term primary. Another reference directs coders to report code 425.4 for dilated cardiomyopathy due to rheumatic valvular disease when the secondary cause is actually specified.

The National Center for Health Statistics must know that this advice is incorrect. Why is it incorrect? All of the other types of cardiomyopathies that precede code 425.4 (i.e., ICD-9-CM codes 425.0–425.3) are considered primary cardiomyopathies. The codes that appear directly after code 425.4 (i.e., ICD-9-CM codes 425.5 and 425.7–425.9) are considered secondary cardiomyopathies. Code 425.4 is designated for primary cardiomyopathies that don’t fit into code category 425.0–425.3. Code 425.4 also includes various nonessential modifiers (e.g., congestive, constrictive, and familial).

Conditions during the perinatal period

Specific codes in the 740–759 range denote congenital anomalies—conditions related to the development of the fetus. Codes 760–763 denote maternal conditions causing perinatal morbidity and mortality of the newborn. Codes 764–779 denote other conditions originating in the perinatal period. With the exception of codes 770–779, the conditions described are those that originate at birth as well as those that are identified at birth or that can be traced back to birth. The code titles refer to the transition from intrauterine existence to life in the outside world as well as events that can occur at the time of birth.

Why do codes 770–779 confuse coders? Official coding guidance directs coders to assign these codes for infants under the age of 28 days. This is considered the newborn period even if a condition that is identified has nothing to do with being newly born.

The World Health Organization understands the intent of these codes, and the rest of the world uses these codes for events related to the process of being born. So it’s not surprising that statistics demonstrate that the United States has more perinatal problems than other nations—we’re the only ones misusing the codes. For example, a coder assigns one of these codes for a respiratory condition (e.g., a cold) that the patient contracts from his brother 27 days after birth. Although this is technically accurate according to official coding guidance, this and other similar code assignments may drive MS-DRG assignments that can be deceptive. A higher-weighted MS-DRG that denotes a complicated delivery depicts this particular scenario.
Similarly, code 648.2x denotes anemia in the mother that has the potential to complicate pregnancy, childbirth, or the puerperium. This includes any anemia (e.g., sickle cell anemia, Mediterranean anemia, toxic anemia, or deficiency anemia) that has the potential to cause problems for the mother or the fetus during pregnancy, the delivery, or the immediate postnatal period. This code is not intended for anemia that occurs after a child is born. Again, the World Health Organization knows that all codes in the 648 and 649 series represent conditions that must exist throughout most, if not all, of the duration of the pregnancy. Yet official coding guidance directs coders to report code 648.22 for patients who develop anemia after the birth of the child. This guidance corrupts research and data tracking relative to mothers with anemia.

**SIRS and sepsis**

I’ve written extensively about the inappropriate coding advice that directs coders to assign code 038 for SIRS with infection when the patient isn’t sick. The most respected critical care physicians in the world support my argument. There is a consensus among physicians that sepsis is not instantly present when the patient has SIRS plus an infection with no other supporting evidence that he or she is sick. Yet official coding guidelines and other published guidance persist. This is despite the fact that the Cooperating Parties were aware of the clinical consensus when they finalized the 995.9x series of codes related to infection. It’s not surprising, then, that the incidence of sepsis DRGs in the United States rose from 310,000 in 2004 to 750,000 in 2008. The Recovery Auditors use these numbers as justification to target these DRGs and take money back in many instances.

**Acute respiratory distress syndrome**

There are various problems with reporting code 518.82 for acute respiratory distress syndrome (ARDS). In 1993, the definition for this code changed from ARDS to also include acute respiratory distress. Why is this incorrect? Acute respiratory distress doesn’t include the term *syndrome.* The physician who led the international conference that prompted the change in definition of 518.82 in 1993 has written a letter to the NCHS explaining this error. Although the error will be corrected in ICD-10-CM, it remains uncorrected in ICD-9-CM. What does this mean for Medicare and Medicaid? Both insurers will continue to lose massive amounts of money.

**Sharing thoughts and ideas**

As always, we invite your feedback and input regarding this and all topics addressed in “Clinically Speaking.” Contact us with potential topics, questions, or ongoing coding or documentation dilemmas that you’d like me to address in this column. Alternatively, send coding-related questions and thoughts to Lisa Eramo, contributing editor, at leramo@hotmail.com.

**Editor’s note:** Dr. Gold is CEO of DCBA, Inc., a consulting firm in Atlanta that provides physician-to-physician CDI programs. Contact him at 770-216-9691 or rgold@DCBAInc.com.
Inpatient wound care

Test your knowledge with some challenging Q&As

Inpatient wound care coding has always been fraught with documentation challenges.

What specific documentation constitutes excisional debridement? Upon whose documentation can coders rely? When is a query for additional information appropriate? These are just some of the questions that coders must ask themselves regularly.

Robert S. Gold, MD, CEO of DCBA, Inc., in Atlanta, and Gloryanne Bryant, RHIA, CCS, CDIP, CCDS, an HIM consultant in Fremont, Calif., with more than 30 years of experience, answered the following questions during HCPro’s audio conference “Inpatient Wound Care Coding: Clinical Information and Documentation Strategies.”

Robert S. Gold, MD

Q Which code should we assign if a physician documents only excisional debridement—and nothing else—in an inpatient progress note?

A Although Coding Clinic, First Quarter 2008, p. 3 advises coders to assign ICD-9-CM procedure code 86.22 (excisional debridement of wound, infection, or burn) when physicians explicitly document excisional debridement, this code may not be the most appropriate choice.

Coders should never code solely from the title of an operative report. They must know the details of the precise procedure the physician performed. If the physician documented using a scalpel to perform debridement down to and including muscle, code 86.22 is not appropriate. Coders should instead report a more appropriate code for debridement of the muscle.

If documentation states the physician performed debridement down to and including muscle and bone, code 86.22 is also not appropriate. Coders should instead report a more appropriate code for the debridement of the bone.

Coders must always validate in the body of the operative report/note exactly what the physician performed. If they are unable to validate this information, they should query the physician for clarification.

Q A patient presents with a gangrenous amputation stump due to arterial insufficiency. An orthopedist must debride considerable gangrenous necrotic tissue before closing the wound. Sometimes, the bone is shortened during the same session so the physician can advance tissue over the bone end. How should we code this?

A Excisional debridement is likely quite clear in the operative report. However, coders must remember that the debridement is integral to the revision of the amputation stump. As such, coders should only report a code for the revision—not the debridement. Refer to Coding Clinic, Second Quarter 1998, p. 15 for more information.

Q How should staff approach physicians with education regarding the importance of accurate inpatient wound care documentation?

A Peer-to-peer education is always helpful. It would be beneficial for CDI and coding staff to partner with physicians to assist with messaging. Use actual case examples so physicians better understand any documentation challenges. Value-based purchasing and severity-adjusted profiles that will affect reimbursement are also concepts that staff can use to their advantage.

Q If a certified wound care nurse provides excisional debridement, must a physician still provide an order for these services? If so, does the consultation order for evaluation and treatment suffice?

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A Wound care doesn’t necessarily require a physician order because it may be standard protocol when patients present with wounds. Thus, a standing order protocol should be on file and available in the record. Conversely, state law may require an order for surgical excisional debridement. Each state has a scope of practice for providers of medical care, which includes a description of the services that certified wound care nurses may render as well as any requirements related to those services. However, the more pressing question is whether it’s truly excisional debridement.

Q A wound care nurse documents that a pressure ulcer is debrided with scissors. The nurse describes the amount of the wound that is debrided (i.e., 15% of the wound). How should we code this?

A I believe this represents selective debridement (ICD-9-CM procedure code 86.28), but you should validate this with your wound care team. Documentation for excisional debridement doesn’t depend on a percentage of the wound debrided. However, physicians must document excision of the necrotic or devitalized tissue—not simply that they trimmed pieces.

Q Does removal of eschar constitute excisional debridement?

A Documentation of removal of eschar is insufficient to report excisional debridement. Coding Clinic, Fourth Quarter 2000, p. 68 instructs coders to report ICD-9-CM code 86.09 (other incision of skin and subcutaneous tissue) when providers perform escharotomy. Prior to October 1, 2000, coders reported code 86.22 (excisional debridement of wound, infection, or burn). More specific documentation should describe the details of the removal, including the following:

- Pre- and post-diagnosis (indications)
- Procedure title
- Procedure details (e.g., measurement of wound dimensions, type and method of debridement, depth of the wound [subcutaneous, muscle, or bone], and a description of what tissue was removed)
- Instruments used
- Results post-procedure

Q Can you clarify the difference between sharp and excisional debridement?

A Sharp debridement has a vague connotation. It can include something as simple as snipping one tiny piece of necrotic tissue to the removal of the entire wound, including the edges (which would constitute excision of the entire wound). The term *sharp* doesn’t denote exactly what procedure the provider performed. Coders must clarify definitions for excisional/surgical debridement or non-excisional debridement and ensure that everyone uses these definitions when documenting in the medical record. Provider education regarding documentation requirements and definitions may be necessary.

Q What additional documentation, if any, will ICD-10-CM require with respect to pressure ulcers?

A ICD-10-CM will require the specific location of the pressure ulcer and laterality. Physicians won’t need to identify the stages of the wounds; they can simply identify the deepest tissue involved with the pressure ulcer.

Gloryanne Bryant, RHIA, CCS, CDIP, CCDS

Q Can hospitals develop charges for bedside procedures associated with inpatient wound care and debridement?

A Yes, hospitals can develop charges for these procedures. Room and board fees wouldn’t include costs associated with bedside procedures. Room and board charges cover the normal care and services provided without surgical intervention. For example, room and board charges often include equipment to weigh patients,
Must providers specify the square footage of the debrided area in addition to mentioning the layers of tissue that they debrided?

**A** CPT requires providers to document the specific size and dimensions of the debrided area when they perform wound care. However, on the inpatient side, it isn’t required for ICD-9-CM code assignment. Including both the square footage of the debrided area and the specific layers of tissue debrided so there is no question about what the provider did is best practice. Providers also benefit from more specific documentation because this is also required for professional billing.

Must providers reach healthy, bleeding, subcutaneous tissue to code excisional debridement, provided all other documentation requirements are met?

**A** No. Excisional debridement sometimes requires extensive work, and providers may not actually reach healthy tissue during the first or second debridement treatment sessions. Some debridement occurs in stages because patients can’t tolerate it all at once. The healing process takes time. Also, no official source requires this documentation at this time.

Wound care staff performs wound care staging. May coders use the wound care nurses’ notes when coding and query them directly instead of querying a physician?

**A** In the inpatient setting, yes, coders can code from wound care notes that wound care nurses provide, if wound care services are within their scope of practice. Coding Clinic has provided guidance; providers other than physicians can perform and document excisional debridement procedures. I’ve seen query forms developed for physicians and other practitioners, such as wound care nurses. If a wound care nurse provides documentation, you may need to query that individual directly.

Editor’s note: For more information about the audio conference, visit [http://tinyurl.com/c48k5aq](http://tinyurl.com/c48k5aq).
Editor’s note: Answers to the following questions are based on limited information submitted to Briefings on Coding Compliance Strategies. Review all documentation specific to your scenario before determining appropriate code assignment.

How will ICD-10-CM affect the coding of congenital spinal conditions?

Congenital anomalies of the spine may be documented as simple (e.g., no spinal deformity) or complex (e.g., severe spinal deformity, cor pulmonale, or paraplegia). The most common congenital spinal deformities are the following:

- Hyperlordosis
- Kyphosis
- Scoliosis

Coders currently report ICD-9-CM code 754.2 (certain congenital musculoskeletal deformities of the spine) to denote any of these three conditions.

As expected, ICD-10-CM includes more detailed descriptions for reporting spinal conditions. For example, congenital kyphosis requires additional characters based on the specific location of the deformity. In ICD-10-CM, coders must choose from among the following codes for congenital kyphosis:

- Q76.415—Congenital kyphosis, thoracolumbar region
- Q76.419—Congenital kyphosis, unspecified region

Congenital lordosis (Q76.42-) has a similar added level of specificity with regard to the region affected. Therefore, when using ICD-10-CM, coders will need to identify the specific region involved from the physician documentation, something currently not required with ICD-9-CM.

A physician documents a diagnosis of acute blood loss anemia secondary to acute upper GI hemorrhage and duodenal ulcer. Should we report ICD-9-CM code 532.40 (duodenal ulcer with hemorrhage) and ICD-9-CM code 285.1 (acute post-hemorrhagic anemia)?

Query the physician to determine whether the duodenal ulcer caused the GI bleeding.

If the physician performed an endoscopy and determined that the duodenal ulcer is the site of the bleeding, report ICD-9-CM code 532.40. Don’t report code 532.40 if the physician did not perform an endoscopy and did not identify the cause or site of the bleeding. The physician must correlate the relationship between the ulcer and the GI hemorrhage before you can report code 532.40.

Coding Clinic, Second Quarter 2007, p. 13 provides clarification regarding GI bleeding with a single finding. It states that coders “should not assume a causal
My question pertains to transplant complications. If a complication affects a transplanted organ, should coders assign a code for the transplant complication?

Consider the following physician documentation: “Final A/P: Acute renal failure in patient with history of renal transplant.” Should coders report 996.81 (complications of transplanted kidney) and 584.9 (acute kidney failure, unspecified)?

Also consider this documentation: “CHF in heart transplant patient.” Should coders report 996.83 (complications of transplanted heart) and 428.0 (congestive heart failure [CHF], unspecified)?

When a condition affects a transplanted organ, coders should report a complication code as the first-listed diagnosis followed by a code for the type of complication. This is true even when the provider doesn’t document a relationship between the complication and the transplanted organ.

Section I.C.17.f.2.b of the ICD-9-CM Official Guidelines for Coding and Reporting states:

Codes under subcategory 996.8, Complications of transplanted organ, are for use for both complications and rejection of transplanted organs. A transplant complication code is only assigned if the complication affects the function of the transplanted organ.

Several questions and answers in the same issue of AHA Coding Clinic® further clarify when a transplant complication code should be reported. Two organs specifically addressed are the heart and kidney. When coding CHF in a transplanted heart, assign code 996.83 and the applicable 428.- code even if the patient had a history of CHF prior to transplant. When coding acute renal failure in a transplanted kidney, assign code 996.81 and the applicable 584.- code. The guidance demonstrates that providers don’t need to specify a condition affecting a transplanted organ as a complication for use of these transplant complication codes. However, there is an exception regarding chronic kidney disease ( CKD ) and renal transplants. In some cases, transplantation may not fully restore kidney function. Coding guidelines state that when this occurs, coders should “assign the appropriate 585 code for the patient’s stage of CKD and code V42.0 unless the documentation is unclear in which case the provider needs to be queried.” The guidelines further state:

Conditions that affect the function of the transplanted kidney, other than CKD, should be assigned code 996.81, Complications of transplanted organ, Kidney, and a secondary code that identifies the complication.

Cheryl Ericson, MS, RN, CCDS, CDIP, CDI education director at HCPro, Inc., in Danvers, Mass., answered this question, which originally appeared on JustCoding.com.