ICD-10 Coding Corner

Recap of Coding Clinic, Second Quarter 2013

Editor’s note: AHA Coding Clinic for ICD-9-CM released its third round of ICD-10 coding guidance in its Second Quarter 2013 issue. HCPro CDI Education Director Cheryl Ericson, MS, RN, CCDS, CDIP, AHIMA approved ICD-10-CM/PCS trainer, says the guidance contains several questions about procedures which may be problematic for coders. Organizations have to decide whether their CDI specialists will query for procedures beyond clarifying excisional from non-excisional debridement as they do today, says Ericson.

Other important updates in this issue include entries on decompensated systolic congestive heart failure (CHF), anticoagulation therapy, and use of sign/symptom/unspecified codes. The following is a recap of the issue with an eye toward what it means for CDI specialists.

General coding updates

The 2014 ICD-10-CM Official Guidelines for Coding and Reporting were published recently (view them on the Centers for Disease Control and Prevention website: www.cdc.gov/nchs/data/icd9/icd10cm_guidelines_2014.pdf) and contain some updates that are cross-referenced in this issue of Coding Clinic, Ericson says.

“Overall, we’re still seeing Coding Clinic providing advice about shortcomings of the ICD-10 code set,” she says. “Some people were hoping that everything would have a specific code, but some of the examples show that you will have to use an ‘other specified’ or ‘not elsewhere classified’ code.”

For example, on p. 31, Coding Clinic states to use “other specified conductive disorders” to report a diagnosis of short QT syndrome. And on p. 32, Coding Clinic states that documentation of acrokeratosis paraneoplastica, Basex syndrome goes to L98.8, other specified disorder of the skin. These entries serve as a broader reminder of the differences between unspecified and other specified codes.

“Unspecified” means that there is a lack of documentation [available] to assign to a more specific code, whereas ‘other specified’ means that the physician gave us more detail than the code set can accommodate,” she says. “We’re not going to teach the physician to be more general—you don’t want to do that.”

It will be confusing (and time-consuming) to CDIs and coders alike when they are unable to assign a specific code for some diagnoses as occurs today with the ICD-9-CM code set, Ericson says.

“It will be a trial-and-error process as the CDI staff learns which diagnoses don’t have specific codes within the ICD-10-CM code set,” she says.

It is a concern also seen in pregnancy diagnosis coding, including entries on intrauterine device placement (p. 34), intrauterine pressure monitoring (p. 36), and determining weeks of gestation (p. 33).

“It’s not relevant to traditional CDI efforts, but we’re seeing more CDI staff review pediatric and obstetric populations because of changes in Medicaid payments,” she says. “In ICD-10, older grouper payment systems will no longer be supported, so many payers have to adopt a new payment strategy or begin using MS-DRGs or APR-DRG groupers for claims processing. Whenever patients can be stratified into one or more groups, CDI specialists can have an impact, so we’re seeing CDI expand into other patient populations to ensure patients are classified accurately into the different groups. Doing so can impact reimbursement and quality metrics.”

On p. 31, Coding Clinic reiterates that E codes remain voluntary for reporting, but Ericson says to be wary of thinking that rule of thumb applies in every instance. “Some combination codes such as poisoning and toxic effects traditionally required E codes in ICD-9 for clarification of the circumstances of the event. This information will now be captured using combination codes,” she says. “That means the additional information won’t always be voluntary.”

CHF, anticoagulation therapy

“The big win” in this issue of Coding Clinic is advice regarding decompensated systolic CHF (p. 33). The question references a previous Coding Clinic (Third Quarter 2008,
(p. 12) that equated decompensated systolic heart failure to acute on chronic systolic heart failure.

“There is no coding guideline and the ICD-10 tabular list does not carry that concept into ICD-10,” Ericson says. “We didn’t know if this concept would be retained in ICD-10 but someone specifically referenced the 2008 Coding Clinic to see if it applies in ICD-10-CM.”

In response, Coding Clinic clearly states to assign I50.23, Acute on chronic systolic heart failure, for decompensated systolic heart failure. Be forewarned, however, decompensated is not synonymous with exacerbated, Ericson says.

“We’re still looking for guidance whether the term ‘exacerbated’ will still mean acute on chronic for specified heart failure in the ICD-10 code set,” she says. “As long as the physician documents decompensated, we’re okay, but if he or she says exacerbated, we may still need to query for acute on chronic. So it’s a partial win. Semantics are everything in coding. Provider terminology has to be exact for a code to be accurately applied.”

Coding Clinic also provides additional clarification regarding anticoagulation therapy (p. 34). Ericson says an ongoing source of confusion is that anticoagulation therapy is the same as coagulopathy. Within the ICD-10-CM codes set (as was the case within the ICD-9-CM) a coagulopathy is an acquired condition, whereas if the use of medication is involved it’s either an adverse effect or a poisoning.

Coding Clinic, Second Quarter 2013, pulls this concept forward into ICD-10-CM with an entry on Warfarin-Induced skin necrosis, which codes to I96 (Gangrene), followed by a T code for the adverse effect of the anticoagulant.

“This is consistent with advice we’ve seen through ICD-9 Coding Clinic,” Ericson says. “However, I wish their advice was even more specific and stated that the use of the T code for adverse effect is based on the assumption that the medication was correctly prescribed and correctly administered, as we wouldn’t want inexperienced CDI specialists and/or coders thinking these situations are always adverse effects. This type of over coagulation can also result from a poisoning, which would change the sequencing of the diagnoses.”

**Specified vs. unspecified codes and diagnostic testing**

On p. 30, Coding Clinic discusses the use of specific diagnosis codes vs. unspecified codes, stating that “each encounter must be coded to the level of certainty known for that encounter.”

The entry is critical, Ericson says, as it discusses the balancing act between selecting the most specific code possible—the role of the CDI professional—versus conducting medically unnecessary diagnostic testing to achieve a more specific code. The latter should never be done, Coding Clinic states:

> It would be inappropriate to select a specific code that is not supported by the medical record documentation or conduct medically unnecessary diagnostic testing in order to determine a more specific code.

“They are saying don’t increase the cost of healthcare by ordering a more specific test if it’s not going to help the treatment plan,” she says.

Ericson cites the example of an echocardiogram to diagnose the type of heart failure. Providers often rely on documentation of an ejection fraction (EF) of less than 40% to classify heart failure as systolic. However, Ericson notes that it doesn’t make sense to perform an echo test for every admission if the focus of the admission is not the heart failure just to obtain an EF to specify systolic and diastolic, because an echo from a year ago can still be valid (if the patient is stable, and not coming in because of aggravation of heart failure), she says.

“That’s when CDI specialists look for clinical indicators, including past echo results, to support a query for specificity if the term CHF is documented. We want to be as specific as possible, but you don’t want to perform unnecessary tests. At the same time we need to be sure that the documentation does support coding to the highest specificity allowed within the code set, so a query should be issued if more specificity is available within the code set per coding guidelines,” she says.

Organizations must decide whether it is the role of CDI or coding to query for increased code specificity if it won’t impact reimbursement or other CDI performance indicators. Organizations will not be penalized for the use of unspecified codes, but many industry professionals believe unspecified codes will eventually lose their CC or MCC designation to encourage the use of specificity within the ICD-10-CM code set.

Eventually, “who does this type of querying could change over time,” she says.