The close of 2013 brought with it two more issues of Coding Clinic for ICD-9-CM that included some valuable guidance on the nation’s soon-to-be coding system, ICD-10. As has been the case with previous issues, the greater focus is on procedures (ICD-10-PCS) rather than diagnoses.

Here is a review of what was discussed and why it matters to CDI professionals.

### Third Quarter 2013

This issue was relatively light but did have a few items worth noting.

On p. 18, Coding Clinic states that the coding of a peripherally inserted central catheter (PICC) depends on the end placement of the PICC line—that is, where the device ends up. This is not necessarily a big deal for CDI specialists, as it won’t affect reimbursement, but it does stress that we need accurate documentation to support these bedside procedures. Look for the body part where the device ends up to determine your fourth PCS character in ICD-10.

On p. 20, Coding Clinic states that it is not appropriate to assign code E10.65 (Type 1 diabetes mellitus with hyperglycemia) with code E10.10 (diabetes ketoacidosis). Essentially, Coding Clinic states that uncontrolled diabetes is integral to ketoacidosis, and therefore should not be reported separately. This is a noteworthy change from ICD-9, but again has no reimbursement impact.

On the same page, a discussion of glenoid labrum repair highlights the anatomy and physiology demands ICD-10 places on coding staff. Coding Clinic notes that a glenoid labrum is classified as a ligament.

Body parts won’t be as straightforward in ICD-10 and coders may struggle to select the correct code. Coders will need access to the Internet to search for anatomy terms like a glenoid labrum in order to identify that it is a ligament. Some organizations limit Internet access due to the distraction, but CDI specialists and coders will need a medical search function.

An entry on p. 23 (catecholaminergic tachycardia, or CPVT) shows the limitations of ICD-10, which, though more specific than ICD-9, is not as
specific as people think, as Coding Clinic says that all ventricular tachycardias are classified to I47.2.

There is one other item of interest in the Third Quarter edition on p. 27 that is of direct relevance to CDI specialists and might be the most important piece of advice from this particular issue. It concerns whether codes can be taken from prior encounters—for example, taking an echocardiogram from an old record to assign a more specific type of heart failure. Coding Clinic states that codes cannot be assigned in this manner, as conditions documented on previous encounters may not be clinically relevant to the current encounter.

Everyone agrees that you would never retrieve a diagnosis or code from a previous record. However, I wish Coding Clinic was clearer here, as CDI specialists may still look for a previous clinical indicator to clarify (not code) a diagnosis in the present record. For example, it’s not reasonable for an echocardiogram to be done each visit—these tests can have a shelf life of one to two years, so if a physician documents CHF, unspecified, you can use the past echo to query for the specific type of CHF. This Coding Clinic supports this practice, but they could have worded it better.

Another tip related to this entry is to avoid the problem list in your electronic health record when coding the record. The problem list is a requirement of meaningful use, but you will see diagnoses carry over from a previous stay that are no longer clinically relevant, and therefore should not be coded.

### Fourth Quarter 2013

Coding Clinic, Fourth Quarter 2013 again has a heavy emphasis on procedures. This highlights the relatively unknown impact of procedure coding. PICC lines, etc., occur very commonly, making me feel like there will be more of an impact on productivity than people are predicting. There is also a lot of information about obstetrics in this issue, an area that traditionally CDI specialists don’t review, but we will see more of a focus on this as state Medicaid payers move to reimbursing under APR-DRGs.

On p. 108 we get to our first really helpful guidance for CDI. There is a question about whether to code tobacco use as dependence if the physician documents the patient is a “smoker.” Coding Clinic states to code to dependence. As a CDI specialist, we’re going to want to find out whether the patient is also experiencing withdrawal. Most hospitals are non-smoking environments, and when you put a patch on a patient, they may be already starting withdrawal. It’s a perfect query opportunity if a person is getting a patch, whether the physician is treating withdrawal or whether it’s prophylactic for withdrawal. Nicotine dependence with withdrawal is a CC.

Related to this concept, someone also asks (bottom of p. 108) Coding Clinic to define when to use nicotine dependence. Coding Clinic responded that it’s at the physician’s discretion. It would protect facilities more if they have a consensus on the definition of withdrawal—for example, five hours or 24 hours without nicotine.
Continuing this theme of reviewing records of smokers, on p. 109 a question asks whether COPD can be assumed to be caused by cigarettes in a long-term smoker. *Coding Clinic* reminds us that there is no assuming in coding, and the COPD would be coded as unspecified (unless the CDI specialist clarifies this issue with the physician).

Take note of the guidance on p. 114 as it’s a huge change. *Coding Clinic*, First Quarter 2004 allows us to assume the relationship of diabetes and osteomyelitis when both are present, unless a physician says otherwise. However, *Coding Clinic* says that we can no longer make that assumption in ICD-10. We don’t run into this scenario very often, but this underscores the fact that we can’t assume the guidance *Coding Clinic* issued for ICD-9 will also be true in ICD-10.

On p. 115, *Coding Clinic* notes that you should not use General Equivalency Mappings to assign codes. Some organizations use complex mapping tools to help coders map ICD-9 codes over to ICD-10, but this *Coding Clinic* reinforces that everything needs to be directly coded to ICD-10, not converted from an ICD-9 code. It makes me wonder how this will work in terms of payers, who frequently map from ICD-9 to ICD-10 when paying claims.

The discussion on p. 118 asks whether hemoptysis can be reported when it occurs with pneumonia. *Coding Clinic* says it should be added as an additional code, as it is not routinely associated with the diagnosis of pneumonia. The takeaway here is about what is integral vs. nonintegral, and this helps us know that hemoptysis is not routinely associated with pneumonia.

We unfortunately get some confusing guidance from an entry on p. 119 related to a patient admitted with severe sepsis due to healthcare-associated pneumonia. *Coding Clinic* states that it is appropriate to assign code Y95 (Nosocomial condition) for this encounter. This may leave people thinking that hospital-acquired pneumonia is a hospital-acquired condition (HAC), but not everything that happens to a patient in a hospital is a HAC—only a few specific codes.

Nosocomial means occurring during the stay, which could be a quality issue for organizations when a patient comes in with pneumonia. It sounds like *Coding Clinic* is confusing present on admission (POA) with nosocomial, as this entry makes it appear as though the hospital gave the patient the pneumonia. This will add confusion to HACs vs. POAs, and I’m concerned it will open up a can of worms.

On p. 121 *Coding Clinic* states to assign acute respiratory failure, unspecified (J96.00) as principal, and toxic effect of smoke, accidental (T59.811A), along with J70.5, Respiratory conditions due to smoke inhalation, as secondary, in a patient admitted through the ED for smoke inhalation with acute respiratory failure. It’s interesting that we get these mixed messages in the guidelines—even though the patient’s respiratory failure is because of the smoke, it’s still considered the principal diagnosis.
The entry shows you need to look at each case not just to maximize reimbursement, but for overall clarity since acute respiratory failure when designated as the principal diagnosis would have a lower-weighted DRG than if it were listed as secondary, so most coders don’t like to list it first. But you have to do what the guidelines state.

Finally, on p. 124 Coding Clinic states that there is no ICD-10 code for extra-corporeal dialysis. In ICD-9 we had V56.0. Instead, you now have to assign a code for the underlying reason as principal and you can’t assume it is end-stage renal disease (ESRD).

Note that small hospitals admit people for this treatment. As a CDI specialist, make sure you ask the physician to state whether it is for dialysis due to ESRD, or acute renal failure, to get that linkage in the record.

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